

14256

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Mar Penna.</b> b. COUNTY <b>Fulton</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown Md.</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Needmore Penna.</b>   |  |
| c. LENGTH OF STAY IN 1b<br><b>1 Day</b>  |                               | d. STREET ADDRESS<br><b>Needmore Penna.</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>Ellen</b> Last <b>Adelsberger</b>   |                               | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>22</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>F.</b>  | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>9.15.1909</b>           |
| 9. AGE (In years lost birthday) yrs. <b>49</b>   |                               | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>8</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Fulton County Penna.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Blair A Waltz</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Mennie Mellott</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                               | 16. SOCIAL SECURITY NO.<br><b></b>   |  |
| 17. INFORMANT<br><b>Walter E Adelsberger</b>   |                               | Address<br><b>Needmore Penna.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pancreatitis(?)</b><br><b>584x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <b>Cholelithiasis.(?)</b> DUE TO<br>(c) <b></b>   |                               |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>5 years ?</b>  |                               |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Hypertensive cardio-vascular disease; <del>XXXXXX</del></b>  |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m. <b></b>   |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Dec. 21</b> , 19 <b>58</b> , to <b>Dec. 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec. 22</b> , 19 <b>58</b> , and that death occurred at <b>11:20AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>M.D. 138 W. Washington St. Dec. 23, 1958</b><br>DATE SIGNED <b></b> |                               |  |  |
| ACTUAL SIGNATURE <b>Richard V. Hauver</b>  |                               |  |  |
| PHYSICIAN'S NAME (Type) <b>Richard V. Hauver, M. D. Hagerstown, Md.</b>  |                               |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                               | 22b. DATE THEREOF<br><b>22.26.58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Tonoloway Baptist</b>   |                               | 22d. LOCATION (City, town, or county) (State)<br><b>Needmore Fulton Penna.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hauver &amp; Elmore Hagerstown Md</b>   |                               | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                               |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS DEPARTMENT OF HEALTH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14249

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown Rural</b>                                   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>800 Block The Terrace</b>  |                                  |   |  | d. STREET ADDRESS<br><b>Donneybrook Drive R. F. D. 6</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Wilson</b> Last <b>Ard</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>20</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 12, 1924</b>  |  | 9. AGE (In years last birthday)<br><b>34</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Physician</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General practice Bellefonte Penn.</b>   |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Wilson P. Ard</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary A. Bullock</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes W. W. II</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>524-14-2685</b>   |  | 17. INFORMANT<br><b>Mrs. Robert W. Ard Route 6 Hag. Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple fractured ribs</b><br><b>822X</b> DUE TO <b>Haemathorax and shock</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____   |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b>  |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Driver of automobile that turned over</b>                |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>7:12 Dec. 20 '58</b>  |                                  | 20d. INJURY OCCURRED<br>While working <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Street</b>   |  | 20f. (City or town) (County) (State)<br><b>Hagerstown Wash Md</b>                                 |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |                                  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED   |  |
| EXAMINER'S NAME (Type)<br><b>S. Robert Wells, M.D.</b>  |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | <b>12-22-58</b>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>12-23-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son Hagerstown Md.</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 29 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kram</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Washington

Bellevue

Bellevue

Bellevue

Bellevue Drive N. E. D. S.

Robert

Robert

December 20

White

July 12, 1924

Physician

Bellevue Penn.

Wilson

Wilson

Yes W. V. H.

21-1A-2082 Mrs. Robert A. and House 6 Bar. Md.

CONFIDENTIAL

12-23-28

Rose Hill Cemetery

Bellevue

Robert D. Minnich & Son Hagatstown



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14258 CERTIFICATE OF DEATH

14250

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |  |  | c. LENGTH OF STAY IN 1b<br><u>2 Yrs. 1 Mo.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Jackson Convalescent Home</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CARRIE</u> Middle <u>H.</u> Last <u>ARMSTRONG</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>6</u> Year <u>19 58</u>  |  |  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>white</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 8. DATE OF BIRTH<br><u>May 12, 1874</u>  |  |
| 9. AGE (In years last birthday) yrs. <u>84</u>   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Port George, Nova Scotia</u>                           |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Canada</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |  |  |
| 13. FATHER'S NAME<br><u>Capt. James Boyd</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Eleanore Weaver</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>Rev. J. Boyd Davis</u> Address <u>Blue Ridge Summit, Pa.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>493X pneumonia</u><br>DUE TO (b) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic Cardiovascular Disease</u>   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>on Dec 6, 1958</u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.                               |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>J. M. Weeks</u>   |  | M.D. <u>  </u>   |  | ADDRESS (Street, city or town, state)<br><u>136 N Potomac</u>   |  | DATE SIGNED<br><u>12/6/58</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>J. M. WEEKS</u>  |  | <u>Ind.</u>  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |  | 22b. DATE THEREOF<br><u>12/7/1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Pine Grove</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Lynn Massachusetts</u>                     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Kathleen Y. Gore</u>  |  |  |  | ADDRESS<br><u>Waymeston, Pa.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 8 '58</u>   |  |
|  |  |  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Carlton S. Kneass</u>   |  |



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14251

14259 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Penn</b><br>b. COUNTY <b>Franklin</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  | c. LENGTH OF STAY IN 1b<br><b>2 hours</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Line</b> <span style="float: right;">75X-3</span>                   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>W. Washington St.</b>   |  | d. STREET ADDRESS<br><b>Box 123</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nellie</b> Middle <b>Virginia</b> Last <b>Artz</b>   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 17, 1890</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>68</b>  |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine Operator</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Md.</b>                                |
| 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME<br><b>John F. Lum</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Nellie Creager</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>---</b>                                     |   |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Mrs. John Artz</b> Address <b>St. Line Pa.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Cardio Vascular Disease</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Dec 16, 1958</b> to <b>Dec 16, 1958</b> , that I last saw the deceased alive on <b>Dec 16, 1958</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.  |  |   |   |
| ACTUAL SIGNATURE<br><b>J. H. Beachley</b> M.D.   |  | ADDRESS (Street, city or town, state)<br><b>221 W. Washington St.</b> DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. J. H. Beachley</b>   |  | <b>Hagerstown Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>12-19-58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>DEC 22 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kraus</b>  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14323

## CERTIFICATE OF DEATH

14252

Reg. Dist. No.

|   |                        |  |                            |
|---|------------------------|--|----------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY Washington MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Md. b. COUNTY Washington                               |                            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring  |                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring   |                            |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 128  |                        | d. STREET ADDRESS Box 128  |                            |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |  |                            |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last CHARLES E. ATHERTON   |                        | 4. DATE OF DEATH Month Day Year Dec. 10, 1958 19   |                            |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/28/1892 |
| 9. AGE (In years last birthday) 66 yrs.   |                        | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer   |                        | 10b. KIND OF BUSINESS OR INDUSTRY Munitions Depot  |                            |
| 11. BIRTHPLACE (State or foreign country) Mercersburg, Pa., R1  |                        | 12. CITIZEN OF WHAT COUNTRY? USA   |                            |
| 13. FATHER'S NAME B. Frank Atherton   |                        | 14. MOTHER'S MAIDEN NAME Alice Rasp  |                            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no   |                        | 16. SOCIAL SECURITY NO. 188-05-7245  |                            |
| 17. INFORMANT Mrs. Chas. E. Atherton, Clearspring, Md.  |                        | Address Md.  |                            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma - stomach<br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Prostatitis<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                        | INTERVAL BETWEEN ONSET AND DEATH 14X   |                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                            |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                            |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                            |
| 21. I certify that I attended the deceased from Nov. 15, 1957, to Dec 10, 1958, that I last saw the deceased alive on Aug 2, 1958, and that death occurred at 4 P. M. from the causes and on the date stated above.   |                        | ADDRESS (Street, city or town, state) DATE SIGNED  |                            |
| ACTUAL SIGNATURE Philip J. Hirshman   |                        | M.D. 59 W. Washington St. Clearspring, Md. 12/14/58  |                            |
| PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.  |                        |  |                            |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 22b. DATE THEREOF 12/14/58   |                            |
| 22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cem.  |                        | 22d. LOCATION (City, town, or county) (State) Mercersburg, Pa., R. #1  |                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. M. Linger   |                        | ADDRESS Mercersburg, Pa.   |                            |
| 24a. REC'D BY REGISTRAR DATE DEC 15 '58   |                        | 24b. REGISTRAR'S SIGNATURE Arthur S. Klaus   |                            |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 14



## 14260 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>13 Yrs</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>324 Devonshire Road</b>   |  |   |  | e. STREET ADDRESS<br><b>324 Devonshire Road</b>   |  |   |  |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>LEAFY FORREST BLUBAUGH</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 27 1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 16 1912</b>   |  |
| 9. AGE (In years last birthday)<br><b>46</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Point of Rocks Fred Co</b>                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Charles P Shry</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Lee Fry</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>214-09-3836</b>   |  | 17. INFORMANT Address<br><b>Chester W. Blubaugh 324 Devonshire Rd</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>9 months</b>  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None.</b>  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>April 5, 1958</b> , to <b>Dec. 27, 1958</b> , that I last saw the deceased alive on <b>Dec. 27, 1958</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b><br>DATE SIGNED <b>12-29-58</b><br>ACTUAL SIGNATURE <b>R.A. Bell</b><br>M.D. <b>R.A. Bell, M.D.</b><br>PHYSICIAN'S NAME (Type) <b>Hagerstown, Maryland.</b> |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12/30/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash Co Md.</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>   |  |   |  | ADDRESS<br><b>Hagerstown Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 '59</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. [Signature]</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14254

14324

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>(Rural) Samples Manor</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>5 years</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Residence</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X (Rural) Samples Manor</u>                                       |  |
|  |                                  | d. STREET ADDRESS<br><u>Hoffmaster Road</u>  |  |
|  |                                  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>THOMAS</u> First <u>R.</u> Middle <u>BOWERS</u> Last   |                                  | 4. DATE OF DEATH <u>December 19,</u> 19 <u>58</u> Month Day Year   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 14, 1874</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs.   |                                  | IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Janitor</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Theatre</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Sharpsburg, Maryland</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Charles Bowers</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>578-30-5538</u>  |  |
| 17. INFORMANT <u>Mr. Samuel F. Bowers</u> Address <u>R.F.D. # 1, Harpers Ferry, West Va.</u>   |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic ht disease</u><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 minutes</u><br><u>1 year</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Dec 8, 1958</u> to <u>Dec 19, 1958</u> , that I last saw the deceased alive on <u>Dec 8, 1958</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <u>John D. Turco</u> M.D. <u>Sharpsburg, Md</u>   |                                  | DATE SIGNED <u>12/20/58</u>  |  |
| PHYSICIAN'S NAME (Type) <u>JOHN D TURCO</u>  |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                                  | 22b. DATE THEREOF <u>12-23-58</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Samples Manor Cemetery</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Samples Manor, Maryland</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald Eckles</u> ADDRESS <u>Harpers Ferry, W. Va.</u>   |                                  | 24a. REC'D BY REGISTRAR DATE <u>DEC 24 '58</u>   |  |
|  |                                  | 24b. REGISTRAR'S SIGNATURE <u>Clinton S. Haines</u>  |  |







1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14261 CERTIFICATE OF DEATH

14255

Reg. Dist. No.

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b><br>MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b><br>b. COUNTY <b>Wash.</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>17 years</b>   |                                      | d. STREET ADDRESS<br><b>443 N. Mulberry St.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Washington County Hospital</b>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ethel</b> Middle <b>Marie</b> Last <b>Bowman</b>   |                                      | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>21</b> , Year <b>19 58</b>  |   |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>    | 8. DATE OF BIRTH<br><b>April 26, 1902</b>                               |
| 9. AGE (In years last birthday)<br><b>56</b> yrs.  |                                      | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Rubber Prods</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington Co., Md.</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>Henry M. Bowman</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Fannie B. Swope</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>220-16-2000</b>  |   |
| 17. INFORMANT<br><b>Edna V. Dutrow, Hagerstown, Md.</b>  |                                      | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Laennec's Cirrhosis</b><br><b>581.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>July 1, 19 57</b> , to <b>Dec 21, 19 58</b> , that I last saw the deceased alive on <b>Dec 21, 19 58</b> , and that death occurred at <b>11:30 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland</b><br>DATE SIGNED <b>12-23-58</b>  |                                      |  |   |
| ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.   |                                      | 318 North Potomac  |   |
| PHYSICIAN'S NAME (Type) <b>Paul Harrison</b>   |                                      | <b>Hagerstown, Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 22b. DATE THEREOF<br><b>12-24-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Valley Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Smithsburg, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home, Smithsburg, Md.</b>   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kinn</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>  |                                      |  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

## CERTIFICATE OF DEATH

Washington, D.C. 20540

Hagerstown, Md. 21750

Washington County Hospital, 423 N. Liberty St.

Age 58, Sex Male, Race White, Date of Death April 26, 1968

Married, Occupation Laborer

Place of Birth Washington Co., Md.

Henry M. Bowman, Fannie B. Snops

MD-18-1500, John V. Dutton, Hagerstown, Md.

Paul Harrison

12-24-76

Pleasant Valley Dam, Littleton, Md.

Minister Funeral Home, Littleton, Md.



14325

## CERTIFICATE OF DEATH

Reg. Dist. No.

14256

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WASHINGTON</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYER NURSING HOME</u>  |  |  |  | d. STREET ADDRESS <u>ROUTE - 1 -</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANETTE Boyer</u>   |  |  |  | 4. DATE OF DEATH Month Day Year <u>DECEMBER - 3, 1958</u>  |  |  |  |
| 5. SEX <u>FEMALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>APRIL - 2 - 1864</u>   |  |
| 9. AGE (In years last birthday) <u>94</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>JEFFERSON FRED. Co. MD. U.S.A.</u>                |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>JOHN MOSER</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MALINDA BEACHLEY</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  | 17. INFORMANT Address <u>JOHN BOYER KEEDYSVILLE MD. R. 1</u>                                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Senile arteriosclerosis</u><br>DUE TO <u>Fractured of right hip</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 weeks</u><br>DUE TO (c) <u>5 yrs</u> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.9</u>  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>Nov 19, 1958</u> to <u>Dec 3, 1958</u> , that I last saw the deceased alive on <u>Dec 3, 1958</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>G. W. Williams</u> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>   |  | DATE SIGNED <u>12/5/58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>G. W. Williams</u>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>Dec. 6, 1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VIEW CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>BURKETTSTVILLE MD.</u>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Bast</u> ADDRESS <u>Boonsboro Md</u>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>DEC 9 58</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Maud</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14262 CERTIFICATE OF DEATH

14257

Reg. Dist. No. 302

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WASHINGTON</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>WASHINGTON</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAGERSTOWN</u>  |  |  |  | c. LENGTH OF STAY IN 1b<br><u>20 YEARS</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>212 MEALEY PARKWAY</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>AGNES Josephine Brunner</u>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><u>DEC 1 1958</u>   |  |  |  |
| 5. SEX<br><u>FEMALE</u>  |  | 6. COLOR OR RACE<br><u>WHITE</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>June 30 1893</u>                                    |  |
| 9. AGE (In years last birthday)<br><u>65 yrs.</u>  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>JOHNSTOWN PENNSYLVANIA</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>John OLSON</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>AUGUSTA PETERSON</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  | 17. INFORMANT Address<br><u>Carle Ann Brunner 1027 PIN OAK ROAD HAGERSTOWN Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>353.3 Died during convulsive seizure</u><br>DUE TO (b) <u>Epilepsy</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Unknown (found dead) 16 years</u>                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I attended the deceased from <u>9-21-1939</u> , to <u>12-1-1958</u> , that I last saw the deceased alive on <u>9-16-58</u> , and that death occurred at <u>about 7 A.M.</u> from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John H. Hornbaker</u>  |  |  |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>154 West Washington St., 12:1:58</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>   |  |  |  | Hagerstown, Md.  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 22b. DATE THEREOF<br><u>12/3/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>REST HAVEN CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>HAGERSTOWN Md.</u>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>C. M. Rouger Hagerstown Maryland</u>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 4 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                       |  |







14263

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>                                      |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Wash. County Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>1 807 Hamilton Blvd</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MILDRED BAKER BYER</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 19 1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 26 1903</b> | 9. AGE (In years last birthday)<br><b>55</b> yrs.   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md. Old Braddock Fred. Co</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John W.B. Summers</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Grace R. Baker</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT Address<br><b>Rev Paul H. Byer 801 Wayne Ave</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b><br>DUE TO (c) <b>Arterio sclerotic Heart Disease</b>                              |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b><br><b>6 hrs.</b><br><b>?</b>                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|  |                                  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>12-19</b> , 19 <b>58</b> , to <b>12-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12-19</b> , 19 <b>58</b> , and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>214 N. Potomac st Hagerstown, Md.</b> DATE SIGNED <b>12/20/58</b> |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D.  |                                  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>  |                                  |   |  | <b>Hagerstown, Md.</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12/22/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. O Md.</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>   |                                  |   |  | ADDRESS<br><b>Hagerstown Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 23 '58</b>   |  |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kiser</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. The first step in the process of creating a business plan is to conduct a thorough market research. This involves identifying the target market, understanding the needs and preferences of the customers, and analyzing the competitive landscape. Market research can be conducted through various methods, including surveys, interviews, and focus groups.



## 14264 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>11 hours</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Washington</b>   |                                  | e. STREET ADDRESS<br><b>Route 5</b>  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Unnamed child of Charles E. Cline</b>  |                                  | 4. DATE OF DEATH Month Day Year<br><b>December 31 19 58</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH<br><b>December 31-58</b> |
| 9. AGE (In years last birthday) yrs. Months Days<br><b>11 40</b>   |                                  | 10. IF UNDER 1 YEAR Months Days<br><b>11 40</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>Charles E. Cline</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Thelma L. Rohrer</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>   |                                  | 16. SOCIAL SECURITY NO. <b>--</b>  |   |
| 17. INFORMANT Address<br><b>Charles E. Cline Hag. Rt. 5</b>  |                                  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Premature</b><br><b>762.5</b> DUE TO <b>Hyalin Membrane Disease (Atelectasis)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Caesarean delivery for placenta previeu- mother has diabetes M</b>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>none 19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>  |                                  | 20f. (City or town) (County) (State)<br><b>- - -</b>   |   |
| 21. I certify that I attended the deceased from <b>Dec. 31</b> , 19 <b>58</b> , to <b>Dec. 31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec. 31</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>  |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>115 N. Potomac St. 1-2-59</b>  |   |
| PHYSICIAN'S NAME (Type) <b>S. Robert Wells</b>   |                                  | <b>Hagerstown Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-2-59</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Smithsburg Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son</b>  |                                  | ADDRESS<br><b>Hagerstown Md.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>JAN 5 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081324XV3







## 14265 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |   | c. LENGTH OF STAY IN 1b<br><u>DOA</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Wash. Co. Hospital</u>   |   | e. STREET ADDRESS<br><u>709 George St.,</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u>Frank</u> Last <u>Cook</u>   |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>17</u> Year <u>19 58</u>   |   |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 8, 1888</u>  |
| 9. AGE (In years lost birthday)<br><u>70</u> yrs.  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hagerstown Water Dept. Penna.</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Penna.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>unknown</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |   | 16. SOCIAL SECURITY NO.<br><u>212-38-8525</u>   |   |
| 17. INFORMANT<br><u>Mrs. Margaretta Cook</u>   |   | Address<br><u>Hagerstown, Md.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial Infarction</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general arteriosclerosis with</u><br>(c) <u>arteriosclerotic heart disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostate hypertrophy</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min</u><br><u>12 yr</u>                         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. _____<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) _____ (County) _____ (State) _____                                    |
| 21. I certify that I attended the deceased from <u>Oct 12, 1958</u> , to <u>Dec 17, 1958</u> , that I last saw the deceased alive on <u>Dec. 11, 1958</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. <u>217 W. Washington St.</u> <u>12-19-58</u><br>PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto</u> <u>111</u> <u>Hagerstown, Maryland</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   | 22b. DATE THEREOF<br><u>12-20-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill</u>  | 22d. LOCATION (City, town, or county) _____ (State) _____<br><u>Hagerstown</u> <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Kraiss</u>  |   | ADDRESS<br><u>Hagerstown, Md.</u>   | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 22 '58</u>   |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14326** Item 4 Film 6237 12-29-58 et  
**CERTIFICATE OF DEATH**

14261

Reg. Dist. No.

|  |                                  |   |   |   |  |  |  |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport Md RFD 2</u>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><u>50 yrs.</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Pinesburg</u>   |                                  |   |   | d. STREET ADDRESS<br><u>Pinesburg</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Cornelia</u> Middle <u>Josephine</u> Last <u>Corderman</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>24</u> Year <u>1958</u>  |  |  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 14 1881</u>   | 9. AGE (In years last birthday)<br><u>77</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>10</u>                      |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Fairview Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   |
| 13. FATHER'S NAME<br><u>Andrew Nelson Trumppower</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Licinda Repp</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   | 17. INFORMANT<br><u>Mr. Hollie A. Palmer</u>  |  | Address <u>Pinesburg RFD 2 Williamsport Md RFD</u>                                     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>                                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)           |
| 21. I certify that I attended the deceased from <u>12/23/58</u> , 19 <u>58</u> to <u>12/24/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/23/58</u> , 19 <u>58</u> and that death occurred at <u>9 PM</u> M, from the causes and on the date stated above.                                    |                                  |   |   |   |  |  |  |
| ACTUAL SIGNATURE<br><u>M. H. Young</u>   |                                  |   |   | ADDRESS (Street, city or town, state)<br><u>Williamsport Md</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u></u>   |                                  |   |   | DATE SIGNED<br><u>12/25/58</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>Dec. 27-58</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Broadfording Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Maryland</u>          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Alfred K. Williamsport Md</u>   |                                  |   |   | ADDRESS<br><u></u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 29 '58</u>                                      |  |
|  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>C. E. K. K. K.</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14266

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

W. Va.

b. COUNTY

Berkeley

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown Md.

c. LENGTH OF STAY IN 1b

3 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Marlowe W. Va.

85x-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Washington County Hospital

d. STREET ADDRESS

Falling Waters RFD 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

## 3. NAME OF DECEASED (Type or print)

First Lloyd

Middle Raymond

Last Dorrance

## 4. DATE OF DEATH

Month Dec.

Day 28

Year 19 58

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

Sept. 23 1885

## 9. AGE (In years last birthday)

73 yrs.

## IF UNDER 1 YEAR

Months 3 Days 4 Hours Min.

## IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ice man Self Employed Ice Manufacture Ohio

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U. S. A

## 13. FATHER'S NAME

John Dorrance

## 14. MOTHER'S MAIDEN NAME

Barbara Elizabeth Fuss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

234-38-9422

## 17. INFORMANT

Mrs. Della Hixon Marlowe Falling Waters W. Va RFD 1

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

593x

DUE TO

Uremia &amp; pulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Renal shutdown

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

none

## 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec 16, 1958 to Dec 28, 1958 that I last saw the deceased alive on Dec 28, 1958, and that death occurred at 7:45 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE

M. Byrket

M.D.

ADDRESS (Street, city or town, state)

284 W Patomac

DATE SIGNED

12-28-58

PHYSICIAN'S NAME (Type)

M. Byrket

M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec. 31-58

22c. NAME OF CEMETERY OR CREMATORY

Harmony Cemetery

22d. LOCATION (City, town, or county)

Near Marlowe W. Va.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Albert L. Leaf Williamsport Md

24a. REC'D BY REGISTRAR

DATE DEC 31 '58

24b. REGISTRAR'S SIGNATURE

Orlino S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14327

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                      |   |  |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport</u>   |                                      | c. LENGTH OF STAY IN 1b<br><u>2 wks, 3 das.</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Williamsport Sanitarium</u>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>03 Hagerstown</u>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      | d. STREET ADDRESS<br><u>921A Lanvale St.</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JULIA</u> Middle <u>C.</u> Last <u>DOWNIN</u>   |                                      | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>12</u> Year <u>19 58</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 23, 1871</u>                               |
| 9. AGE (In years last birthday)<br><u>86</u> yrs.   |                                      | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Tilghmanton, Wash. Co. Md.</u>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Thomas Wolf</u>   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Carty</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                      | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  |
| 17. INFORMANT<br><u>Mr. Earl McCauley</u>   |                                      | Address<br><u>906 Mulberry Ave. Hagerstown, Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u><br>DUE TO<br>(c) <u>  </u> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><u>36 hrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>   |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>19</u>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>1 Aug.</u> , 19 <u>58</u> , to <u>12 Dec.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 Dec.</u> , 19 <u>58</u> and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.   |                                      |   |  |
| ACTUAL SIGNATURE<br><u>Max E Byrkit</u>   |                                      | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>28 W Potomac</u> <u>12-13-58</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>Max E Byrkit</u>  |                                      | <u>Williamsport, Md.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>12/15/58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>   |                                      | 24a. REC'D BY REGISTRAR<br><u>Dec 15 '58</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>William C. Stork U-Pres.</u>   |                                      |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14328

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>2 years</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mennonite Nursing Home</u>   |  |  |  | e. STREET ADDRESS <u>125 N. Locust St.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Lillie Mae Dunahugh</u> First Middle Last   |  |  |  | 4. DATE OF DEATH <u>December 8 1958</u> Month Day Year   |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Nov. 21, 1882</u>                                     |  |
| 9. AGE (In years last birthday) <u>76</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Maugansville Md.</u>         |  |
| 13. FATHER'S NAME <u>Cahrles Dunahugh</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Martha Rumberger</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <u>214-09-7073</u>   |  | 17. INFORMANT <u>Mrs. Miriam Highbarger</u> Address <u>Hagerstown Md.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>443x</u> DUE TO <u>Aperturated Cerebral Vascular System</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 years</u><br>DUE TO (c) |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
|  |  |  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <u>7-1-57</u> , 19 <u>57</u> , to <u>12-8-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-7-58</u> , 19 <u>58</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u>  |  |  |  | ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>12/8/58</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>DR F.W. [Signature]</u>   |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>12-10-58</u>      |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u> ADDRESS <u>Hagerstown Md.</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                             |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                        |  |                        |  |                       |  |                           |  |                           |  |
|------------------------|--|------------------------|--|-----------------------|--|---------------------------|--|---------------------------|--|
| NAME OF DECEASED       |  | SEX                    |  | AGE                   |  | DATE OF BIRTH             |  | PLACE OF BIRTH            |  |
| JAMES H. HARRIS        |  | MALE                   |  | 45                    |  | JAN 15 1880               |  | BALTIMORE, MARYLAND       |  |
| RESIDENCE              |  | OCCUPATION             |  | CAUSE OF DEATH        |  | MANNER OF DEATH           |  | PLACE OF DEATH            |  |
| 1234 E. BALTIMORE ST.  |  | LABORER                |  | HEART DISEASE         |  | NATURAL                   |  | HOSPITAL                  |  |
| DATE OF DEATH          |  | TIME OF DEATH          |  | HOURS OF DEATH        |  | MINUTES OF DEATH          |  | SECONDS OF DEATH          |  |
| JAN 20 1920            |  | 10:00 AM               |  | 10:00                 |  | 00                        |  | 00                        |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF WITNESSES |  | SIGNATURE OF DECEASED |  | SIGNATURE OF FUNERAL HOME |  | SIGNATURE OF BURIAL PLACE |  |
| J. H. HARRIS           |  | J. H. HARRIS           |  | J. H. HARRIS          |  | J. H. HARRIS              |  | J. H. HARRIS              |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE      |  | DATE OF SIGNATURE     |  | DATE OF SIGNATURE         |  | DATE OF SIGNATURE         |  |
| JAN 20 1920            |  | JAN 20 1920            |  | JAN 20 1920           |  | JAN 20 1920               |  | JAN 20 1920               |  |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18



14329

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |                                       |  |  |  |  |  |
|--|--|---------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |  |                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>BERKLEY CO.</u>      |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>  |  |                                       |  | c. LENGTH OF STAY IN 1b <u>4 YEARS</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY-KEEDY MEMORIAL HOME</u>  |  |                                       |  | d. STREET ADDRESS <u>MARTINSBURG, MOLEIR AVE. EXTENDED</u>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                       |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Margaret C. Entler</u> First Middle Last  |  |                                       |  | 4. DATE OF DEATH <u>Dec 3 1958</u> Month Day Year  |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept. 30 1875</u>  |  |
| 9. AGE (In years lost birthday) <u>83</u> yrs.   |  | IF UNDER 1 YEAR Months Days           |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>  |  |                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Md.</u>                         |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |                                       |  |  |  |  |  |
| 13. FATHER'S NAME <u>Joseph Snyder</u>   |  |                                       |  | 14. MOTHER'S MAIDEN NAME <u>VIRGINIA WATSON</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or date of service)</u>  |  |                                       |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <u>MRS MARGARET KNIFE, WASHINGTON 5, D.C.</u> Address <u>528 0 ST NW</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lobar Pneumonia</u><br>DUE TO (c) |  |                                       |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u>  |  |                                       |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |                                       |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                 |  |
| 20f. (City or town) (County) (State)   |  |                                       |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>February 1958</u> to <u>December 3 1958</u> , that I last saw the deceased alive on <u>Dec. 3 1958</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.  |  |                                       |  |  |  |  |  |
| ACTUAL SIGNATURE <u>G. W. H. Van</u>   |  |                                       |  | ADDRESS (Street, city or town, state) <u>Boonsboro, Md.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>G. W. H. Van</u>  |  |                                       |  | DATE SIGNED <u>12/4/58</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>Dec. 6, 1958</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>GREEN HILL CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>MARTINSBURG W. VA.</u>                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Kegelschatz and Coffman</u> ADDRESS <u>Martinsburg, W. Va.</u>   |  |                                       |  | 24a. REC'D BY REGISTRAR DATE <u>DEC 9 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                           |  |                            |  |                            |  |                            |  |                          |  |
|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. NAME OF DECEASED       |  | 2. SEX                     |  | 3. AGE                     |  | 4. DATE OF BIRTH           |  | 5. PLACE OF BIRTH        |  |
| JAMES J. JONES            |  | M                          |  | 45                         |  | 10/15/1915                 |  | NEW YORK, N.Y.           |  |
| 6. OCCUPATION             |  | 7. CAUSE OF DEATH          |  | 8. MANNER OF DEATH         |  | 9. PLACE OF DEATH          |  | 10. DATE OF DEATH        |  |
| Clerk                     |  | Heart Disease              |  | Natural                    |  | Home                       |  | 10/25/1960               |  |
| 11. SIGNATURE OF DECEASED |  | 12. SIGNATURE OF WITNESSES |  | 13. SIGNATURE OF PHYSICIAN |  | 14. SIGNATURE OF REGISTRAR |  | 15. SIGNATURE OF CLERK   |  |
|                           |  |                            |  |                            |  |                            |  |                          |  |
| 16. PLACE OF INTERMENT    |  | 17. NAME OF INTERMENT      |  | 18. DATE OF INTERMENT      |  | 19. NAME OF INTERMENT      |  | 20. DATE OF INTERMENT    |  |
| Catholic Cemetery         |  | St. James                  |  | 10/26/1960                 |  | St. James                  |  | 10/26/1960               |  |
| 21. NAME OF FUNERAL HOME  |  | 22. NAME OF FUNERAL HOME   |  | 23. NAME OF FUNERAL HOME   |  | 24. NAME OF FUNERAL HOME   |  | 25. NAME OF FUNERAL HOME |  |
| St. James                 |  | St. James                  |  | St. James                  |  | St. James                  |  | St. James                |  |
| 26. NAME OF FUNERAL HOME  |  | 27. NAME OF FUNERAL HOME   |  | 28. NAME OF FUNERAL HOME   |  | 29. NAME OF FUNERAL HOME   |  | 30. NAME OF FUNERAL HOME |  |
| St. James                 |  | St. James                  |  | St. James                  |  | St. James                  |  | St. James                |  |

Wm. Jones



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14266

## 14267 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |   | c. LENGTH OF STAY IN 1b<br><b>03</b> years   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>113 S. Prospect Street</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>PAUL</b> First Middle <b>SEPTIMUS</b> Last <b>FECHTIG</b>   |   | 4. DATE OF DEATH <b>December</b> Month <b>25</b> Day <b>19</b> Year <b>58</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 10, 1883</b>                                 |
| 9. AGE (In years last birthday) <b>75</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired buyer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Silk Mill</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown, Md.</b>          |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13. FATHER'S NAME<br><b>Dr. George Fechtig</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Louise H. Doyle</b>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>   |  |
| 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>Mr. Alexander C. Fechtig Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 Coronary thrombosis</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                          |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Dec 24, 1958</b> , to _____, 19____, that I last saw the deceased alive on <b>Dec 24, 1958</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>170 W. Washington St. Hagerstown, Md.</b><br>DATE SIGNED <b>Dec 26, 1958</b> |   |  |  |
| ACTUAL SIGNATURE <b>R. S. Stauffer</b>   |   | M.D. <b>170 W. Washington St. Hagerstown, Md.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>R. S. STAUFFER</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE OF REPO<br><b>12/29/1958</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. Franklin Pitzer</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>                         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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14330

## CERTIFICATE OF DEATH

14267

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NORTH MAIN STREET</u>   |  |  |  | e. STREET ADDRESS <u>NORTH MAIN STREET</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>INEZ EUDORA FLOOK</u>  |  |  |  | 4. DATE OF DEATH Month Day Year <u>DECEMBER 24 19 58</u>   |  |  |  |
| 5. SEX <u>FEMALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>MARCH 23 1897</u>  |  |
| 9. AGE (In years last birthday) <u>61</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> |  | 11. BIRTHPLACE (State or foreign country) <u>MIDDLETOWN FRED. CO. MD. U.S.A.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                   |  |
| 13. FATHER'S NAME <u>JOHN V. ALEXANDER</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MAUDIE YOUNG</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <u>212-14-7533</u>   |  | 17. INFORMANT <u>JOHN J. FLOOK</u> Address <u>BOONSBORO MD.</u>              |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with</u><br><u>420.0</u> DUE TO <u>myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs +</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |  |  |  | 20g. (City or town) _____ (County) _____ (State) _____   |  |  |  |
| 21. I certify that I attended the deceased from <u>Jan 1946</u> , to <u>24 Dec 1958</u> , that I last saw the deceased alive on <u>20 Dec 1958</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>F. F. Lusby</u>   |  |  |  | ADDRESS (Street, city or town, state) <u>2501 P. Thomas</u> DATE SIGNED <u>20 Dec 58</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>  |  |  |  | M.D. <u>Hagerman</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>DEC 27 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u> ADDRESS <u>Boonsboro Md</u>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>JAN 2 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14268 CERTIFICATE OF DEATH

14268

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>o. STATE <u>Pa.</u><br>b. COUNTY <u>Franklin</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Greencastle</u> 75x-3                                     |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Wash. Co. Hospital</u>  |   | d. STREET ADDRESS<br><u>RD2 - Greencastle</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Solomon</u> First <u>J.</u> Middle <u>Foreman</u> Last  |   | 4. DATE OF DEATH <u>Dec.</u> Month <u>25</u> Day <u>1958</u> Year  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 25, 1878</u> 80 yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARM</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>FRANKLIN Co., Pa.</u>                          |
| 13. FATHER'S NAME<br><u>SAMUEL Foreman</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Annie STAMY</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| 17. INFORMANT <u>Ralph Foreman - Greencastle, Pa.</u>  |   | Address <u>RD2 - Greencastle, Pa.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular disease</u><br><u>422.1</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>myocardial dilatation</u><br>DUE TO<br>(c) _____ |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Hour a. m. _____ p. m. _____<br>Month _____ Day _____ Year <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) _____ (County) _____ (State) _____   |
| 21. I certify that I attended the deceased from <u>12/11/58</u> 19____, to <u>12/25/58</u> 19____, that I last saw the deceased alive on <u>12/25/58</u> 19____, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <u>W.C. Brewer</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>12/26/58</u>  |  |
| PHYSICIAN'S NAME (Type) <u>W.C. BREWER</u>   |   | <u>GREENCASTLE, PA.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>12/28/58</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Greencastle, Pa.</u>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Winnich - Greencastle, Pa.</u>  |   | 24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>   |  |
|  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>  |  |







14269

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b<br><b>ONE WEEK</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>WASHINGTON COUNTY HOSPITAL</b>                                      |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>MT. LENA RURAL</b><br>d. STREET ADDRESS<br><b>BOONSBORO MD. ROUTE 2</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>THEODORE R. FORREST</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 29 1958 19</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>                                |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>JANUARY 13 1917 41 yrs.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>GOODWILL INDUSTRIES</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>MT. LENA WASH. CO. MD. U.S.A.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN A. FORREST</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY E. LONGNECKER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED SERVICE? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>213 16 0053</b>                   |  | 17. INFORMANT<br><b>MRS. IRENE FORREST BOONSBORO MD. R. 2</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>757.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Polycystic kidneys</b><br>DUE TO (c)  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>Bilateral</b><br><b>2 years</b>          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|  |  |   |  | 20f. (City or town)<br>(County)<br>(State)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that I attended the deceased from <b>12-24-58</b> , 19____, to <b>12-29-58</b> , 19____, that I last saw the deceased alive on <b>12-29-58</b> , 19____, and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>115 King St., Hagerstown, Md.</b><br>DATE SIGNED _____ |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Frank G. Crisp</b> M.D. <b>115 King St., Hagerstown, Md.</b>   |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Joseph C. Crisp, M.D.</b> <b>115 King St., Hagerstown, Md.</b>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>JANUARY 1 1959</b>                      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT. LENA CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>MT. LENA WASH. CO. MD.</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Bast</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                            |  |                            |  |                        |  |                               |  |                                  |  |                              |  |
|----------------------------|--|----------------------------|--|------------------------|--|-------------------------------|--|----------------------------------|--|------------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                     |  | 3. AGE                 |  | 4. RACE                       |  | 5. DATE OF BIRTH                 |  | 6. PLACE OF BIRTH            |  |
| JAMES H. HARRIS            |  | Male                       |  | 45                     |  | White                         |  | 1880                             |  | Maryland                     |  |
| 7. DATE OF DEATH           |  | 8. TIME OF DEATH           |  | 9. PLACE OF DEATH      |  | 10. CAUSE OF DEATH            |  | 11. MANNER OF DEATH              |  | 12. SIGNATURE OF PHYSICIAN   |  |
| 1925                       |  | 10:00 AM                   |  | Home                   |  | Heart Disease                 |  | Natural                          |  | J. H. HARRIS                 |  |
| 13. SIGNATURE OF REGISTRAR |  | 14. SIGNATURE OF WITNESSES |  | 15. SIGNATURE OF CLERK |  | 16. SIGNATURE OF DEPUTY CLERK |  | 17. SIGNATURE OF ASSISTANT CLERK |  | 18. SIGNATURE OF CHIEF CLERK |  |
| J. H. HARRIS               |  | J. H. HARRIS               |  | J. H. HARRIS           |  | J. H. HARRIS                  |  | J. H. HARRIS                     |  | J. H. HARRIS                 |  |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICS.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14270

Reg. Dist. No.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Williamsport,</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington County Hospital</b>  |  | d. STREET ADDRESS<br><b>R # 2</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Lorraine Marie French</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec 7 19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 22, 1929</b>             |
| 9. AGE (In years last birthday)<br><b>29 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Wash County</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>George Teach</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Guessford</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-245-635</b>   |  |
| 17. INFORMANT<br><b>Mr. Robert French - Williamsport, Md R #2</b>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pancreatitis with hemorrhage with</b><br><b>587.0</b> DUE TO <b>fat necrosis of peritoneum</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Undetermined - pending autopsy report</b><br>DUE TO (c)  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>None 19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>None</b>   | 20f. (City or town) (County) (State)<br><b>- - -</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>S. Robert Wells, M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12-9-58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Green Lawn</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Williamsport, Wash Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Albert Leaf</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 10 '58</b>   |  |
|  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Anthony S. Krasa</b>   |  |

MEDICAL CERTIFICATION

81

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Date of Death: 10-15-1968

3. Place of Death: Home

4. Age: 45 Sex: M

5. Race: W Color: W

6. Marital Status: M

7. Occupation: Teacher

8. Cause of Death: Myocardial Infarction

9. Manner of Death: Natural

10. Signature of Examiner: [Signature]

11. Date of Report: 10-16-1968

12. Name of Hospital: None

13. Name of Physician: Dr. Smith

14. Name of Coroner: Mr. Jones

15. Name of Medical Examiner: Dr. Brown

16. Name of Assistant Medical Examiner: Mr. White

17. Name of Pathologist: Dr. Green

18. Name of Anatomist: Mr. Black

19. Name of Forensic Pathologist: Dr. Blue

20. Name of Toxicologist: Mr. Red

21. Name of Radiologist: Dr. Yellow

22. Name of Psychiatrist: Dr. Purple

23. Name of Social Worker: Ms. Orange

24. Name of Nurse: Ms. Pink

25. Name of Chaplain: Rev. Brown

26. Name of Funeral Home: Mr. Green

27. Name of Cemetery: St. Mary's

28. Name of Burial Place: St. Mary's

29. Name of Interment: St. Mary's

30. Name of Burial Site: St. Mary's

31. Name of Burial Site: St. Mary's

32. Name of Burial Site: St. Mary's

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98. Name of Burial Site: St. Mary's

99. Name of Burial Site: St. Mary's

100. Name of Burial Site: St. Mary's



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Countersigned   |  |  |  |  |                               |  |  |  |  | Maryland Department of Health—BALTIMORE, 18  |  |  |  |  |  |  |  |  |  | 14271   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Dec. 30-1958  |  |  |  |  |                               |  |  |  |  | DME Wash. Co. Item 20 Film 237 1-19-59 ams   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| S. Robert Wells, M.D., CERTIFICATE OF DEATH 14271   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | Reg. Dist. No.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u> |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | c. LENGTH OF STAY IN 1b <u>25 days</u>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u> 06X-2 ✓ |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md State Hospital</u>   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | d. STREET ADDRESS <u>52 Middle Street</u>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>ANNA</u> First Middle Last   |  |  |  |  |                               |  |  |  |  | 4. DATE OF DEATH <u>DECEMBER 30</u> Month Day Year   |  |  |  |  |  |  |  |  |  | 1958  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 5. SEX <u>FEMALE</u>  |  |  |  |  | 6. COLOR OR RACE <u>White</u> |  |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 8. DATE OF BIRTH <u>NOV. 20, 1873</u>  |  |  |  |  | 9. AGE (In years lost birthday) <u>85</u> yrs.                            |  |  |  |  | IF UNDER 1 YEAR Months Days Hours Min. |  |  |  |  | IF UNDER 24 HRS.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>Taneytown, Maryland</u>                                      |  |  |  |  |   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>HENRY GALT</u>   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ANN ELIZA ANNAN</u>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |  |   |  |  |  |  | 17. INFORMANT Address                  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>9040</u> <u>Confluent Lobular Pneumonia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Closed Fracture, left hip</u><br>DUE TO<br>(c) <u>—</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u><br><u>5 weeks</u> |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Hypertrophy. Benign nephrosclerosis</u>  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in Home</u>                           |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>11/21/58</u><br>p. m.   |  |  |  |  |                               |  |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work  |  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |  |  |  |  | 20f. (City or town) (County) (State)<br><u>Taneytown Carroll Maryland</u> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>DEC 5</u> , 19 <u>58</u> , to <u>DEC 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC 30</u> , 19 <u>58</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Euvaristo R. Landigdal</u> M.D.   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | ADDRESS (Street, city or town, state) <u>Western Md State Hospital</u>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  | DATE SIGNED <u>12-30-58</u>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Euvaristo R. Landigdal</u>   |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | <u>Hagerstown, Md.</u>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  |  |                               |  |  |  |  | 22b. DATE THEREOF <u>11/2/59</u>   |  |  |  |  |  |  |  |  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Piney Creek Cemetery</u>            |  |  |  |  |  |  |  |  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Rural Taneytown Maryland</u>                          |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  | ADDRESS <u>Taneytown, Md.</u>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>   |  |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



CERTIFICATE OF DEATH

Form DHE 100-1

|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
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| 1. NAME OF DECEASED |  | 2. SEX |  | 3. AGE |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. PLACE OF BIRTH |  | 7. MARITAL STATUS |  | 8. OCCUPATION |  | 9. CAUSE OF DEATH |  | 10. PLACE OF DEATH |  | 11. DATE OF DEATH |  | 12. TIME OF DEATH |  | 13. SIGNATURE OF REGISTRAR |  | 14. SIGNATURE OF DECEASED |  | 15. SIGNATURE OF WITNESS |  | 16. SIGNATURE OF PHYSICIAN |  | 17. SIGNATURE OF CHURCH CLERGYMAN |  | 18. SIGNATURE OF BURIAL OFFICIAL |  | 19. SIGNATURE OF FUNERAL HOME |  | 20. SIGNATURE OF OTHER |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                   |  |                   |  |               |  |                   |  |                    |  |                   |  |                   |  |                            |  |                           |  |                          |  |                            |  |                                   |  |                                  |  |                               |  |                        |  |
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE, 18

14272

## CERTIFICATE OF DEATH

14272

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Canada</u> b. COUNTY <u>Ontario</u>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>6 months</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cornwall</u> <u>90 x - 3</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>   |  |  |  | d. STREET ADDRESS <u>10 Timothy Ave</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Catherine Grant</u> First Middle Last   |  |  |  | 4. DATE OF DEATH <u>December 1</u> 19 <u>58</u> Month Day Year   |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>May 28, 1863</u>   |  |
| 9. AGE (In years last birthday) <u>95</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.     |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Williamstown Ont, Can.</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>Canada</u> |  | 13. FATHER'S NAME <u>Alexander McDougall</u>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Margaret McLennan</u>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>  |  |  |  |
| 16. SOCIAL SECURITY NO. <u>--</u>   |  |  |  | 17. INFORMANT <u>Mrs. L. F. McGruer</u> Address <u>Hagerstown Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Closed Fracture neck of right femur</u><br>DUE TO <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic myocardial heart disease with myocardial failure grade iv</u><br>DUE TO (c) <u></u> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on the floor in bedroom</u>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>11:45xxx Nov. 20 1958</u> Hour a. m.  |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>                               |  |
| 20f. (City or town) <u>Hagerstown</u> (County) <u>Wash</u> (State) <u>Md</u>  |  |  |  | 21. I certify that I attended the deceased from <u>Oct. 1950</u> to <u>Nov. 30, 1958</u> , that I last saw the deceased alive on <u>Nov. 26, 1958</u> , and that death occurred at <u>12:30a</u> , from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>   |  |  |  | ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>12-1-58</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>  |  |  |  | Hagerstown, Maryland   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>1-4-58</u>            |  | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Williamstown Ont. Canada</u>                                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son Hagerstown Md.</u> ADDRESS <u></u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 3 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>   |  |







14273

# CERTIFICATE OF DEATH

Reg. Dist. No.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/SS

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY Washington  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland  |  | b. COUNTY Washington  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cedar Lawn, Hagerstown R#2   |  | c. LENGTH OF STAY IN 1b   |  | X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cedar Lawn, Hagerstown R#2  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Cedar Lawn, Hagerstown R#2  |  |   |  | d. STREET ADDRESS<br>Cedar Lawn, Hagerstown R#2   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First LAURA  |  | Middle BESS   |  | Last GROVE  |  | 4. DATE OF DEATH<br>Month Dec. Day 13 Year 1958   |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Aug. 30, 1887   |  |
| 9. AGE (In years last birthday)<br>71 yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  | 11. BIRTHPLACE (State or foreign country)<br>Clarke County, Va.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Joseph Payne  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Belle Rinker  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br>NONE                                 |  | 17. INFORMANT<br>Address<br>1712, Marshall Grove Hagerstown Md R#2  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 525X Pneumonia secondary to chronic<br>DUE TO (b) Interstitial fibrosis -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492X arteriosclerotic heart disease - general arteriosclerosis   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from Nov 1, 1957, to Dec 13, 1958, that I last saw the deceased alive on Dec 11, 1958, and that death occurred at 3:20 P. M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md.<br>DATE SIGNED 12-13-58<br>ACTUAL SIGNATURE Edward W. Ditto M.D.<br>PHYSICIAN'S NAME (Type) Dr. E. W. Ditto 111<br>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial<br>22b. DATE THEREOF 12/16/58<br>22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery<br>22d. LOCATION (City, town, or county) (State) Hagerstown Md.<br>23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.<br>24a. REC'D BY REGISTRAR DATE DEC 18 '58<br>24b. REGISTRAR'S SIGNATURE Arthur S. Hauer |  |   |  |   |  |   |  |

Wm. G. Horst O-Peru







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14274

14332

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RFD. Boonsboro (Tilghmington)</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RFD. Boonsboro, Md. near Tilghmington.</u>                           |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | d. STREET ADDRESS   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Lula Belle Grove</u>   |                                  | 4. DATE OF DEATH Month Day Year<br><u>December 12th 19 58.</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 6th 1887.</u> |
| 9. AGE (In years lost birthday)<br><u>71</u> yrs.   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House-wife, (retired)</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Jefferson County, W. Va.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |   |
| 13. FATHER'S NAME<br><u>Zachariah Taylor Fleming, (dec)</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Amanda Isabelle Wilt, (dec)</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><u>Charles Junior Grove (son)</u>  |                                  | Address <u>RFD. Boonsboro, Md</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Day</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>12/12/58</u> to <u>12/12/58</u> , that I last saw the deceased alive on <u>12/12/58</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.                                       |                                  | ADDRESS (Street, city or town, state) DATE SIGNED <u>12/18/58</u>   |   |
| ACTUAL SIGNATURE <u>Raymond Young</u> M.D.  |                                  | PHYSICIAN'S NAME (Type) <u>William J. Ford</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF   |   |
| <u>Burial</u>   |                                  | <u>Dec. 15th 58.</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY  |                                  | 22d. LOCATION (City, town, or county) (State)   |   |
| <u>Edge Hill</u>  |                                  | <u>Charles Town, W. Va.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Melvin T. Stender</u>  |                                  | ADDRESS<br><u>Charles Town, W. Va.</u>  |   |
| 24a. REC'D BY REGISTRAR<br><u>JAN 2 '59</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Frank</u>  |   |



CERTIFICATE OF DEATH

1932

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| <p>NAME OF DECEASED<br/>JAMES H. HARRIS</p>  |  | <p>AGE<br/>65</p>                                |  | <p>SEX<br/>Male</p>                        |  | <p>RACE<br/>White</p>   |  | <p>DATE OF DEATH<br/>April 1, 1932</p> |  |
| <p>PLACE OF DEATH<br/>Home</p>               |  | <p>STREET ADDRESS<br/>1234 N. E. Street</p>      |  | <p>CITY<br/>Baltimore</p>                  |  | <p>STATE<br/>Maryland</p>                                     |  | <p>COUNTY<br/>Baltimore</p>            |  |
| <p>DATE OF BIRTH<br/>March 17, 1867</p>      |  | <p>PLACE OF BIRTH<br/>Baltimore, Md.</p>         |  | <p>EDUCATION<br/>High School</p>           |  | <p>OCCUPATION<br/>Carpenter</p>                               |  | <p>RELIGION<br/>Roman Catholic</p>     |  |
| <p>CAUSE OF DEATH<br/>Heart Disease</p>      |  | <p>IMMEDIATE CAUSE<br/>Myocardial Infarction</p> |  | <p>INTERMEDIATE CAUSE<br/>Hypertension</p> |  | <p>PREEXISTING DISEASES<br/>Hypertension, Atherosclerosis</p> |  | <p>TOXIC CAUSE<br/>None</p>            |  |
| <p>DATE OF EXAMINATION<br/>April 1, 1932</p> |  | <p>PLACE OF EXAMINATION<br/>Home</p>             |  | <p>EXAMINER<br/>J. H. Smith, M.D.</p>      |  | <p>ASSISTANT EXAMINER<br/>None</p>                            |  | <p>PATHOLOGIST<br/>None</p>            |  |
| <p>DATE OF INTERVIEW<br/>April 1, 1932</p>   |  | <p>PLACE OF INTERVIEW<br/>Home</p>               |  | <p>INTERVIEWER<br/>J. H. Smith, M.D.</p>   |  | <p>ASSISTANT INTERVIEWER<br/>None</p>                         |  | <p>PATHOLOGIST<br/>None</p>            |  |
| <p>DATE OF SIGNATURE<br/>April 1, 1932</p>   |  | <p>PLACE OF SIGNATURE<br/>Home</p>               |  | <p>SIGNATURE<br/>J. H. Smith, M.D.</p>     |  | <p>ASSISTANT SIGNATURE<br/>None</p>                           |  | <p>PATHOLOGIST<br/>None</p>            |  |
| <p>DATE OF FILING<br/>April 1, 1932</p>      |  | <p>PLACE OF FILING<br/>Baltimore</p>             |  | <p>FILER<br/>J. H. Smith, M.D.</p>         |  | <p>ASSISTANT FILER<br/>None</p>                               |  | <p>PATHOLOGIST<br/>None</p>            |  |



14273

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md.</u>  |  | c. LENGTH OF STAY IN 1b<br><u>3 weeks</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Washington County Hospital</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Leona</u> Middle <u>Mable</u> Last <u>Hammond</u>  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>17</u> Year <u>19 58</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug. 8 1891</u>   |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>8</u> Hours <u></u> Min. <u></u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Jacob Poffenberger</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Alice (Unknown)</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  |
| 17. INFORMANT<br><u>Mr. Charles G. Hammond</u>   |  | Address<br><u>Sharpsburg Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anorexia Nervosa</u><br>311X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u><br>DUE TO (c) <u></u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 m</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>19</u> p. m. <u></u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |
| 20f. (City or town)  |  | (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Dec 16th</u> , 19 <u>58</u> , to <u>Dec 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>58</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.                             |  |  |  |
| ACTUAL SIGNATURE<br><u>John D Turco</u>  |  | ADDRESS (Street, city or town, state)<br><u>302 W. POTOMAC ST HAGERSTOWN, MD</u>   |  |
| DATE SIGNED<br><u>DEC 23 '58</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>JOHN D TURCO</u>   |  | <u>HAGERSTOWN, MD</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Dec. 20 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. View Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Sharpsburg Md.</u>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert Leaf Williamsport, MD</u>  |  | ADDRESS<br><u></u>   |  |
| 24a. REC'D BY REGISTRAR<br><u>DEC 23 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles S. Kraus</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1912

|                        |  |                      |  |                      |  |                   |  |                    |  |                    |  |                        |  |                      |  |                               |  |                              |  |                                 |  |                                |  |
|------------------------|--|----------------------|--|----------------------|--|-------------------|--|--------------------|--|--------------------|--|------------------------|--|----------------------|--|-------------------------------|--|------------------------------|--|---------------------------------|--|--------------------------------|--|
| NAME OF DECEASED       |  | AGE                  |  | SEX                  |  | RACE              |  | DATE OF BIRTH      |  | PLACE OF BIRTH     |  | CITY OF BIRTH          |  | COUNTRY OF BIRTH     |  | DATE OF DEATH                 |  | PLACE OF DEATH               |  | CITY OF DEATH                   |  | COUNTRY OF DEATH               |  |
|                        |  |                      |  |                      |  |                   |  |                    |  |                    |  |                        |  |                      |  |                               |  |                              |  |                                 |  |                                |  |
| CAUSE OF DEATH         |  | DISEASE              |  | SYMPTOMS             |  | TREATMENT         |  | PREVIOUS ILLNESS   |  | PREVIOUS SURGERY   |  | PREVIOUS TRAUMA        |  | PREVIOUS ACCIDENT    |  | PREVIOUS POISON               |  | PREVIOUS DRUGS               |  | PREVIOUS ALCOHOL                |  | PREVIOUS TOBACCO               |  |
|                        |  |                      |  |                      |  |                   |  |                    |  |                    |  |                        |  |                      |  |                               |  |                              |  |                                 |  |                                |  |
| MANNER OF DEATH        |  | PLACE OF DEATH       |  | DATE OF DEATH        |  | TIME OF DEATH     |  | TEMPERATURE        |  | PULSE              |  | RESPIRATION            |  | BLOOD PRESSURE       |  | WEIGHT                        |  | HEIGHT                       |  | BUILD                           |  | COMPLEXION                     |  |
|                        |  |                      |  |                      |  |                   |  |                    |  |                    |  |                        |  |                      |  |                               |  |                              |  |                                 |  |                                |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF WITNESS |  | SIGNATURE OF CORONER |  | SIGNATURE OF JURY |  | SIGNATURE OF JUDGE |  | SIGNATURE OF CLERK |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF SHERIFF |  | SIGNATURE OF SHERIFF'S DEPUTY |  | SIGNATURE OF SHERIFF'S CLERK |  | SIGNATURE OF SHERIFF'S ATTORNEY |  | SIGNATURE OF SHERIFF'S SHERIFF |  |
|                        |  |                      |  |                      |  |                   |  |                    |  |                    |  |                        |  |                      |  |                               |  |                              |  |                                 |  |                                |  |

1. This certificate is to be filled out by the physician who attended the deceased, or by the coroner if the death was sudden and unexpected, or by the jury if the death was the result of an accident or crime.

2. The cause of death should be stated in full, and the manner of death should be stated in full.

3. The place of death should be stated in full.

4. The date of death should be stated in full.

5. The time of death should be stated in full.

6. The temperature, pulse, respiration, blood pressure, weight, height, build, and complexion should be stated in full.

7. The signature of the physician, witness, coroner, jury, judge, clerk, registrar, sheriff, sheriff's deputy, sheriff's clerk, and sheriff's attorney should be stated in full.

8. The signature of the sheriff's sheriff should be stated in full.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14274 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14276

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>26 months</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Marshall Street</b>  |                                  | d. STREET ADDRESS<br><b>434 Virginia Ave.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Hutchinson Edwin Harrison</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>31</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 12, 1927</b> |
| 9. AGE (In years last birthday)<br><b>31</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Manager</b>  |                                  | 12. KIND OF BUSINESS OR INDUSTRY<br><b>Credit Bureau</b>  |  |
| 13. BIRTHPLACE (State or foreign country)<br><b>Rock Hill S. C.</b>   |                                  | 14. CITIZEN OF WHAT COUNTRY?  |  |
| 15. FATHER'S NAME<br><b>Hutchinson W. Harrison</b>  |                                  | 16. MOTHER'S MAIDEN NAME<br><b>Mabel Faulk</b>  |  |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give year or dates of service)<br><b>yes W. W. 11</b>  |                                  | 18. SOCIAL SECURITY NO.<br><b>247-32-0012</b>   |  |
| 19. INFORMANT<br><b>Mrs. Peggy P. Harrison</b>  |                                  | Address<br><b>Hag. Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fractured skull (closed)</b><br>816x DUE TO <b>Multiple Fractured Ribs</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Hemo-pneumothorax</b><br>(a), stating the underlying cause last. DUE TO <b>Hemorrhage and shock</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Driver of auto that hit another auto and overturned</b>  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>5:40 p.m. Dec. 31 19 58</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Street</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Hagerstown Wash Md</b>   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>   |                                  |   |  |
| ACTUAL SIGNATURE: <b>S. Robert Wells</b>  |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <b>S. Robert Wells</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>1-3-59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Grand View</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Rock Hill S. C.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son</b>   |                                  | ADDRESS<br><b>Hagerstown Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>JAN 5 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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ROCK HILL, S. C.



## 14275 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                               | c. LENGTH OF STAY IN 1b<br><b>03</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>131 Wayside Ave.</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>ELIZABETH</b> Middle <b>HAUSE</b> Last   |                               | 4. DATE OF DEATH <b>December</b> Month <b>17</b> Day <b>1958</b> Year  |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>February 21, 1876</b> |
| 9. AGE (In years last birthday) <b>82</b> yrs.  |                               | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Waynesboro, Pennsylvania</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Michael C. Crilly</b>   |                               | 14. MOTHER'S MAIDEN NAME<br><b>Laura C. Lowman</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                               | 16. SOCIAL SECURITY NO. <b>none</b>  |   |
| 17. INFORMANT <b>Mrs. Asher Edelman Hagerstown, Maryland</b>  |                               | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>General arterial sclerosis</b><br>(b) <b>5 days</b><br>(c) <b>10 days</b> |                               | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>12-12-1958</b> to <b>12-17-1958</b> , that I last saw the deceased alive on <b>12-16-58</b> , 19 <b>58</b> , and that death occurred at <b>10:00</b> M., from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <b>J. E. W. Little</b>   |                               | ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>12/17/58</b>   |   |
| PHYSICIAN'S NAME (Type) <b>J. E. W. Little</b>  |                               |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>12/20/1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b>   |                               | ADDRESS <b>Hagerstown, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR <b>DEC 22 1958</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>C. J. O. A.</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1900

|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|------------------|--|-----|--|-----|--|---------------|--|----------------|--|-----------------|--|----------------|--|---------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased |  | Sex |  | Age |  | Date of Birth |  | Place of Birth |  | Usual Residence |  | Cause of Death |  | Date of Death |  | Time of Death |  | Place of Death |  | Signature of Physician |  | Signature of Registrar |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
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|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
|                  |  |     |  |     |  |               |  |                |  |                 |  |                |  |               |  |               |  |                |  |                        |  |                        |  |
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14333

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Boonesboro</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b> 1035.2 ✓   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Reeders Nursing Home</b>  |   | d. STREET ADDRESS<br><b>518 Maple Avenue</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>Clinton</b> Last <b>Heffner</b>  |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>17</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-14-1891</b>   |
| 9. AGE (In years last birthday)<br><b>67</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired B.&amp;O. Car repairman</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Charles W. Heffner</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Mc Kimmy</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mrs. Nora Heffner, Brunswick, Maryland</b>   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Haemorrhage</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b><br><b>2 wks.</b>                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Dec 6</b> , 19 <b>58</b> , to <b>Dec 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 16</b> , 19 <b>58</b> , and that death occurred at <b>5 A.</b> M, from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE <b>G. W. Llewellyn</b> M.D.   |   | ADDRESS (Street, city or town, state) <b>Brunswick</b> DATE SIGNED <b>12/17/58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>G. W. Llewellyn</b>   |   | <b>Ind</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>12-20-58</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Brunswick, Maryland</b>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. H. Lantz</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 23 '58</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hance</b>   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14279

## 14276 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chambersburg</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>3 mos.</b>   |                                  | d. STREET ADDRESS<br><b>943 Wilson Ave.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Garlock Conval. Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cynthia K.</b> Middle <b>Henderson</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>6,</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 14, 1868</b> |
| 9. AGE (In years last birthday) yrs. <b>90</b>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housekeeper</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Marengo, Pa. (Centre Co.) U.S.A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Samuel A. Rider</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Hull</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>-</b>  |  |
| 17. INFORMANT<br><b>Mrs. Paul N. Geyer,</b>  |                                  | Address <b>943 Wilson Ave. Chambersburg, Pa.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO<br>(c) <b>Senility</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b> |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Aug 29 - 1958</b> to <b>Dec 6, 1958</b> , that I last saw the deceased alive on <b>Dec 3 - 58</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>A. W. Orlin</b> M.D. <b>Hagerstown Md</b> <b>12/6/58</b><br>PHYSICIAN'S NAME (Type) <b>Dr E W J. Orlin</b> <b>Hagerstown Md</b>   |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12/9/58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Centre Co. Memorial</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>State College, Pa.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles M. Rouzer, Hagerstown, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 8 '58</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur J. Hager</b>   |                                  |  |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14277

## CERTIFICATE OF DEATH

14282

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 months</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Garlock Memorial Hospital</b>  |  |   |  | e. STREET ADDRESS<br><b>65 East Ave.</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Margaret</b> Last <b>Hoffman</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>8</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 22, 1893</b>  |  |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>03</b> Days <b>03</b> Hours <b>03</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>03</b> Days <b>03</b> Hours <b>03</b> Min.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>house wife</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>house wife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Williamsport, Md.</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Williamsport, Md.</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Williamsport, Md.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>William Davis</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Eckis</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>- -</b>   |  |   |  |
| 17. INFORMANT<br><b>N. Earl Hoffman, Hagerstown, Md.</b>   |  |   |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> <b>Years</b><br>DUE TO (c) |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebral Hemorrhage Sept. 29, 1958 with hemiplegia, rt.</b>  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>March 19, 1958</b> , to <b>Dec. 8, 1958</b> , that I last saw the deceased alive on <b>Dec. 7, 1958</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>119 N. Potomac Street, 12-9-58.</b> DATE SIGNED   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>R. A. Bell</b>  |  |   |  | M.D. <b>119 N. Potomac Street, 12-9-58.</b>   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>R. A. Bell, M. D.</b>  |  |   |  | <b>Hagerstown, Maryland.</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 22b. DATE THEREOF<br><b>12-11-58</b>                                    |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Waynesboro, Penna.</b>                                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 12 '58</b>  |  |   |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>  |  |   |  |







14334

CERTIFICATE OF DEATH

14280

Reg. Dist. No.

|  |                                  |  |                                      |  |   |   |  |
|--|----------------------------------|--|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |                                  |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Boonesboro</b>  |                                  |  |                                      | c. LENGTH OF STAY IN 1b<br><b>1085.2</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Reeder Nursing Home</b>   |                                  |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ella</b> Middle <b>R.</b> Last <b>Hogan</b>  |                                  |  |                                      | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>30</b> Year <b>1958</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-22-1872</b> | 9. AGE (In years last birthday)<br><b>86</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Book keeping</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  |
| 13. FATHER'S NAME<br><b>Michael Hogan</b>  |                                  |  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Virginia Hymes</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT<br><b>Mrs. Catherine Brown, Brunswick, Maryland</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b><br><b>4500</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decongestion of heart</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |  |                                      |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 yrs</b><br><b>4 hrs</b>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July 6, 1958</b> , to <b>Dec. 30, 1958</b> , that I last saw the deceased alive on <b>Dec. 30, 1958</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.   |                                  |  |                                      |  |   |   |  |
| ACTUAL SIGNATURE<br><b>J. W. Leland</b>  |                                  |  |                                      | ADDRESS (Street, city or town, state)<br><b>Boonesboro</b>   |   |   |  |
| PHYSICIAN'S NAME (Type)<br><b>G. W. Leland</b>   |                                  |  |                                      | DATE SIGNED<br><b>12/31/58</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-2-1959</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Brunswick, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. L. Leland</b>  |                                  |  |                                      | ADDRESS<br><b>Brunswick, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 6 '59</b>                            |  |
|  |                                  |  |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hume</b>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|  |  |                                      |  |                                       |  |   |  |                                    |  |                                   |  |
|--|--|--------------------------------------|--|---------------------------------------|--|---|--|------------------------------------|--|-----------------------------------|--|
| NAME OF DECEASED<br>JAMES H. HARRIS    |  | AGE<br>65                            |  | SEX<br>Male                           |  | RACE<br>White                                   |  | DATE OF BIRTH<br>1880              |  | PLACE OF BIRTH<br>Maryland        |  |
| DATE OF DEATH<br>1945                  |  | TIME OF DEATH<br>10:00 AM            |  | PLACE OF DEATH<br>Home                |  | CAUSE OF DEATH<br>Heart Disease                 |  | MANNER OF DEATH<br>Natural         |  | OCCUPATION<br>Retired             |  |
| EDUCATION<br>High School               |  | RELIGION<br>Methodist                |  | MARRIAGE<br>Married                   |  | SPOUSE<br>Mary H. Harris                        |  | CHILDREN<br>3                      |  | Siblings<br>2                     |  |
| PREVIOUS ILLNESS<br>Hypertension       |  | TREATMENT<br>Medication              |  | HISTORY<br>Long                       |  | SYMPTOMS<br>Chest pain                          |  | SIGNS<br>Edema                     |  | LABORATORY<br>None                |  |
| PATHOLOGICAL<br>None                   |  | TOPOGRAPHICAL<br>None                |  | CLINICAL<br>None                      |  | HISTORICAL<br>None                              |  | PHYSICAL<br>None                   |  | PSYCHOLOGICAL<br>None             |  |
| SIGNATURE OF PHYSICIAN<br>J. H. Harris |  | SIGNATURE OF WITNESS<br>J. H. Harris |  | SIGNATURE OF DECEASED<br>J. H. Harris |  | SIGNATURE OF NEAREST RELATIVE<br>Mary H. Harris |  | SIGNATURE OF CLERK<br>J. H. Harris |  | SIGNATURE OF JURY<br>J. H. Harris |  |
| DATE OF SIGNATURE<br>1945              |  | DATE OF SIGNATURE<br>1945            |  | DATE OF SIGNATURE<br>1945             |  | DATE OF SIGNATURE<br>1945                       |  | DATE OF SIGNATURE<br>1945          |  | DATE OF SIGNATURE<br>1945         |  |

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD, HAS RECEIVED THE ABOVE CERTIFICATE OF DEATH FROM THE COUNTY OF BALTIMORE, MD, AND THE SAME IS HEREBY FILED FOR THE PURPOSES OF THE VITAL STATISTICS ACT, CH. 10, § 101, OF THE MARYLAND CODE, 1937, AS AMENDED.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14278

## CERTIFICATE OF DEATH

Reg. Dist. No.

14281

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>20 years</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>295 Frederick Street</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>SIMON</b> First <b>CHESTER</b> Middle <b>HOLZAPFEL</b> Last   |  |  |  | 4. DATE OF DEATH <b>December</b> Month <b>3</b> Day <b>1958</b> Year   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>May 19, 1878</b>                                     |  |
| 9. AGE (In years last birthday) <b>80</b> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Horticulturist</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Business</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown, Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Henry Holzapfel</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha E. Lippel</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT Address<br><b>J. Richard Holzapfel Waynesboro, Pa.</b>     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis due to</b><br><b>420.1</b> DUE TO <b>Arterio sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Thrombosis April 1956</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>April 29, 1956</b> , to <b>Dec. 3, 1958</b> , that I last saw the deceased alive on <b>Dec. 3, 1958</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Adm. Novenstein</b>  |  |  |  | ADDRESS (Street, city or town, state) <b>J. R. Novenstein M.D. 12-3-58</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  | 22b. DATE THEREOF<br><b>12/6/1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>          |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b>   |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Suter-Houzer Funeral Home</b><br><b>R. Franklin Suter</b>   |  |  |  | ADDRESS<br><b>Hagerstown, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 8 '58</b>                              |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, TO FUNERAL DIRECTOR: page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BY CROWTHER-HUTCHINSON TO THE HONORABLE ATTORNEY GENERAL



14335

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Hagerstown</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>33 years</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>R.F.D. # 6</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JULIA</u> Middle <u>BELLE</u> Last <u>IRVING</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>14</u> Year <u>19 58</u>   |  |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>November 23, 1878</u>  |  |
| 9. AGE (In years last birthday)<br><u>80</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Beaver Creek, Maryland</u>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>David Fulton</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Jane Leggett</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  | 17. INFORMANT<br><u>Mrs. Gail Wolfe</u>   |  | Address<br><u>Hagerstown, Maryland</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>260x Arteriosclerotic heart disease city strain 14 yrs.</u><br>DUE TO (b) <u>Diabetes mellitus</u><br>DUE TO (c) <u>Stroke</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>  </u> |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u> |  |
| 20f. (City or town)<br><u>  </u>   |  |   |  | 20g. (County)<br><u>  </u>  |  | 20h. (State)<br><u>  </u>   |  |
| 21. I certify that I attended the deceased from <u>Dec 18</u> , 19 <u>58</u> , to <u>Dec 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>58</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.<br>ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D. <u>159 W. Washington St. Hagerstown Md 21758</u> DATE SIGNED <u>12/15/58</u>   |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>12/17/1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Dunkard Church Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Beaver Creek, Maryland</u>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Suter-Rouzer Funeral Home</u><br><u>K. Franklin Rorer</u>   |  |   |  | ADDRESS<br><u>Hagerstown, Maryland</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 19 1958</u>                                  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>  </u>  |  |   |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14284

14279

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u><br>b. COUNTY <u>Washington</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>Life</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>5 W. Irvin Ave</u>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Irene</u> Middle <u>Josephine</u> Last <u>Jaynes</u>   |                                  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>13</u> Year <u>1958</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 6, 1901</u> |
| 9. AGE (In years last birthday)<br><u>57</u> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Hagerstown Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><u>Lewis W. Maugans</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Cromer</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>---</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>---</u>   |  |
| 17. INFORMANT<br><u>Mr. Sidney B. Jaynes</u>   |                                  | Address<br><u>Hagerstown Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Rheumatoid arthritis</u><br><u>722.0</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u><br>DUE TO (c) <u>---</u>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>12-13</u> , 19 <u>58</u> to <u>12-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-13</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>Paul Harrison</u> M.D. <u>318 N. Potomac St.</u><br>PHYSICIAN'S NAME (Type) <u>Paul Harrison</u> <u>Hagerstown Md.</u> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>12-15-58</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill Cemetery</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Scott F. Minnich &amp; Son</u>  |                                  | ADDRESS<br><u>Hagerstown Md.</u>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 18 '58</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Hume</u>   |  |







FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14285

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  | c. LENGTH OF STAY IN 1b<br><b>life</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA - Emergency Room - Hospital</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Martha Lou Kelbaugh</b>   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>8</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 12, 1942</b>  |
| 9. AGE (In years last birthday)<br><b>15 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>11</b> Days <b></b> Hours <b></b> Min. <b></b>   | 11. IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington County</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Charles Grayson Kelbaugh</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Williams</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   |
| 17. INFORMANT<br><b>Charles G. Kelbaugh-Father- R#1 Hagerstown, Md</b>  |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fractured Skull (Closed)</b><br>812X DUE TO <b>Multiple fracture of ribs</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Fracture right femur (closed)</b><br>(c), stating the underlying cause last. DUE TO <b>Hemorrhage and shock</b>   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)<br><b>Struck by oncoming car while crossing highway</b>        |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>5:15</b> <b>PM</b> <b>Dec. 8 1958</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>  | 20f. (City or town) <b>Rural-Hagerstown, Wash Md</b> (County) <b></b> (State) <b></b> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| DATE SIGNED <b>Dec. 9 '58</b>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>12-11-58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Stouffer's Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington County, Md</b>         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>A.E. Minnick Funeral Home- Greencastle, Pa.</b>  |  | ADDRESS   |   |
| 24a. REC'D BY REGISTRAR<br><b>DEC 15 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles G. Kelbaugh</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 11. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 14281 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |  |   |   |
| c. LENGTH OF STAY IN 1b<br><u>years</u>  |  |   |  | d. STREET ADDRESS<br><u>617 N. Mulberry St.</u>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>617 N. Mulberry St.</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print) <u>MARY E. KELLER</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>21</u> Year <u>19 58</u>   |  |   |   |
| 5. SEX<br><u>female</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>2/17/1871</u>                                    |   |
| 9. AGE (In years last birthday)<br><u>87</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>87</u> Days <u>21</u> Hours <u>19</u> Min. <u>58</u>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>                    |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  | 13. FATHER'S NAME<br><u>Joshua Summers</u>  |  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Leatherman</u>  |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |  |   |   |
| 16. SOCIAL SECURITY NO.<br><u>none</u>   |  |   |  | 17. INFORMANT<br><u>Oscar S. Keller, 617 N. Mulberry St., Hagerstown, Md.</u>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain tumor (type undiagnosed)</u><br><u>237x</u> DUE TO <u>Died during convulsive seizures</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>(c) _____ |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 mos.</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>none</u>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>none</u>   |  |   |   |
| 20c. TIME OF INJURY<br>Hour <u>none</u> a. m. <u>19</u> p. m.  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>none</u>   |  | 20f. (City or town) _____ (County) _____ (State) _____                  |   |
| 21. I certify that I attended the deceased from <u>Oct. 19 48</u> , to <u>Dec. 21, 19 58</u> , that I last saw the deceased alive on <u>Dec. 20, 19 58</u> , and that death occurred at <u>8:05 A.M.</u> from the causes and on the date stated above.   |  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>  |  |   |  | ADDRESS (Street, city or town, state) <u>115 N. Potomac Street- Hagerstown, Md.</u>   |  |   |   |
| DATE SIGNED <u>12-22-58</u>  |  |   |  |   |  |   |   |
| PHYSICIAN'S NAME (Type) <u>Dr. S. R. Wells</u>   |  |   |  | <u>Hagerstown, Md.</u>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   |  | 22b. DATE THEREOF<br><u>12/23/1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Reformed Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Middletown, Md.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Gladhill Co., Middletown, Md.</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 24 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                    |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                           |  |                          |  |                            |  |                        |  |                            |  |                        |  |
|---------------------------|--|--------------------------|--|----------------------------|--|------------------------|--|----------------------------|--|------------------------|--|
| 1. NAME OF DECEASED       |  | 2. SEX                   |  | 3. AGE                     |  | 4. RACE                |  | 5. DATE OF BIRTH           |  | 6. PLACE OF BIRTH      |  |
| JAMES H. HARRIS           |  | Male                     |  | 45                         |  | White                  |  | 1880                       |  | New York, N.Y.         |  |
| 7. DATE OF DEATH          |  | 8. TIME OF DEATH         |  | 9. PLACE OF DEATH          |  | 10. CAUSE OF DEATH     |  | 11. DISEASE OR INJURY      |  | 12. MANNER OF DEATH    |  |
| 1925                      |  | 10:00 A.M.               |  | Home                       |  | Heart Disease          |  | Coronary Artery Disease    |  | Natural                |  |
| 13. SIGNATURE OF DECEASED |  | 14. SIGNATURE OF WITNESS |  | 15. SIGNATURE OF PHYSICIAN |  | 16. SIGNATURE OF CLERK |  | 17. SIGNATURE OF REGISTRAR |  | 18. SIGNATURE OF JUDGE |  |
|                           |  |                          |  |                            |  |                        |  |                            |  |                        |  |
| 19. NAME OF DECEASED      |  | 20. SEX                  |  | 21. AGE                    |  | 22. RACE               |  | 23. DATE OF BIRTH          |  | 24. PLACE OF BIRTH     |  |
| JAMES H. HARRIS           |  | Male                     |  | 45                         |  | White                  |  | 1880                       |  | New York, N.Y.         |  |
| 25. DATE OF DEATH         |  | 26. TIME OF DEATH        |  | 27. PLACE OF DEATH         |  | 28. CAUSE OF DEATH     |  | 29. DISEASE OR INJURY      |  | 30. MANNER OF DEATH    |  |
| 1925                      |  | 10:00 A.M.               |  | Home                       |  | Heart Disease          |  | Coronary Artery Disease    |  | Natural                |  |
| 31. SIGNATURE OF DECEASED |  | 32. SIGNATURE OF WITNESS |  | 33. SIGNATURE OF PHYSICIAN |  | 34. SIGNATURE OF CLERK |  | 35. SIGNATURE OF REGISTRAR |  | 36. SIGNATURE OF JUDGE |  |
|                           |  |                          |  |                            |  |                        |  |                            |  |                        |  |



14282

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |                               |  |                                      |   |  |  |  |
|---|-------------------------------|--|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |                               |  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>   |                               |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WALKER OLIVER KENNEDY</u>  |                               |  |                                      | 4. DATE OF DEATH Month Day Year <u>December 15 1958</u>   |  |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 14 1884</u> |   | 9. AGE (In years last birthday) yrs. <u>74</u> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor W.M.R.R.</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |                                      | 11. BIRTHPLACE (State or foreign country) <u>Va. Greenville Augusta Co</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>John Kennedy</u>   |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <u>Ellen Armstrong</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>-----</u>   |                                      | 17. INFORMANT Address <u>Julia Ann Kennedy 132 E. Antietam St</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary insufficiency and acute pulmonary edema</u><br>DUE TO <u>420.0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u><br>DUE TO (c) _____ |                               |  |                                      |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>20 hours</u><br><u>6 months</u>                         |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lupus erythematosus</u>  |                               |  |                                      |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>December 15, 1958</u> , to <u>December 15, 1958</u> , that I last saw the deceased alive on <u>December 15, 1958</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><u>100 Professional Arts Bldg. 12/16/58</u>         |                               |  |                                      |   |  |  |  |
| ACTUAL SIGNATURE <u>William T. Layman, M.D.</u>   |                               | M.D. <u>100 Professional Arts Bldg. 12/16/58</u>   |                                      |   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>William T. Layman</u>  |                               | <u>Hagerstown</u>  |                                      | <u>Maryland</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>12/18/58</u>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Thurmont Fred Co Md.</u>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>  |                               |  |                                      | 24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14283

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |   |   |   |  |   |
|---|---|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WASHINGTON</u> MARYLAND   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAGERSTOWN</u>   |   |   |   | c. LENGTH OF STAY IN 1b<br><u>NINE DAYS</u>   |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>WASHINGTON COUNTY HOSPITAL</u>   |   |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 4. DATE OF DEATH<br>First Middle Last<br><u>JOHN</u> <u>HAMILTON</u> <u>KEPLER</u>  |   |   |   | Month Day Year<br><u>DECEMBER</u> <u>13</u> <u>1958</u>   |   |  |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>APRIL 14 1880</u>  | 9. AGE (In years last birthday)<br><u>78</u> yrs.   | 10. IF UNDER 1 YEAR: IF UNDER 24 HRS.<br>Months Days Hours Min. |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>RETIRED</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>NEAR MIDDLETOWN FRED. CO. MD. U.S.A.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>        |   |
| 13. FATHER'S NAME<br><u>JOHN H. KEPLER</u>  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><u>SUSAN AHALT</u>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   | 17. INFORMANT<br><u>CYRUS R. KEPLER BOONSBORO MD.</u>   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ |   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs</u>                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |   |   |  |   |
| 21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>58</u> , to <u>Dec 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.                                 |   |   |   |   |   |  |   |
| ACTUAL SIGNATURE<br><u>G. W. L. Van</u>   |   |   |   | ADDRESS (Street, city or town, state)<br><u>Boonsboro Md.</u>   |   |  |   |
| PHYSICIAN'S NAME (Type)<br><u>G. W. L. Van</u>  |   |   |   | DATE SIGNED<br><u>12/13/58</u>  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 22b. DATE THEREOF<br><u>DEC. 15 1958</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>BOONSBORO CEMETERY</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>BOONSBORO WASH. CO. MD.</u> |   |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John H. Bast</u>   |   |   |   | 24a. REC'D BY REGISTRAR<br><u>DEC 18 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Evans</u> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1988

Form 10-100

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY  |  | 2. SEX<br>Male   |  | 3. AGE<br>39   |  | 4. DATE OF BIRTH<br>12/5/48  |  | 5. PLACE OF BIRTH<br>Memphis, Tenn.  |  |
| 6. OCCUPATION<br>Attorney  |  | 7. MARITAL STATUS<br>Single  |  | 8. RACE<br>White   |  | 9. RELIGION<br>Methodist   |  | 10. EDUCATION<br>High School   |  |
| 11. DATE OF DEATH<br>4/4/68  |  | 12. TIME OF DEATH<br>10:00 AM  |  | 13. PLACE OF DEATH<br>Baltimore, Md.   |  | 14. CAUSE OF DEATH<br>Suicide  |  | 15. MANNER OF DEATH<br>Homicide  |  |
| 16. SIGNATURE OF PHYSICIAN<br>[Signature]  |  | 17. SIGNATURE OF CORONER<br>[Signature]  |  | 18. SIGNATURE OF WITNESS<br>[Signature]  |  | 19. SIGNATURE OF DECEASED<br>[Signature]   |  | 20. SIGNATURE OF NEXT OF KIN<br>[Signature]  |  |
| 21. CERTIFICATE OF DEATH<br>This is to certify that the above named person died on the 4th day of April, 1968, at the age of 39 years, of the cause of death stated above. |  | 22. CERTIFICATE OF DEATH<br>This is to certify that the above named person died on the 4th day of April, 1968, at the age of 39 years, of the cause of death stated above. |  | 23. CERTIFICATE OF DEATH<br>This is to certify that the above named person died on the 4th day of April, 1968, at the age of 39 years, of the cause of death stated above. |  | 24. CERTIFICATE OF DEATH<br>This is to certify that the above named person died on the 4th day of April, 1968, at the age of 39 years, of the cause of death stated above. |  | 25. CERTIFICATE OF DEATH<br>This is to certify that the above named person died on the 4th day of April, 1968, at the age of 39 years, of the cause of death stated above. |  |

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON DIED ON THE 4TH DAY OF APRIL, 1968, AT THE AGE OF 39 YEARS, OF THE CAUSE OF DEATH STATED ABOVE.



14284

## CERTIFICATE OF DEATH

Reg. Dist. No.

14289

302

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b><br>MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b>         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>30 Yrs</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1112 Rose Hill Ave</b>  |  |   |  | d. STREET ADDRESS<br><b>1112 Rose Hill Ave</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>HENRY</b> Last <b>KOOGLE</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>17</b> Year <b>19 58</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 13 1884</b>  |  |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cabinet Builder</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Myersville Fred Co Md</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>Jacob Koogle</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Poffenberger</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>214-09-2628</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs Jean Eckard 1701 Salem Ave Extd Hagerstown Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral metastasis</b><br><b>163X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma, Left Lung</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>1 yr</b>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |   |  |
| 21. I certify that I attended the deceased from <b>Oct 17, 1958</b> , to <b>17 Dec 58</b> , that I last saw the deceased alive on <b>15 Dec 58</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>135 NO POTOMAC ST HAGERSTOWN, MARYLAND</b><br>DATE SIGNED <b>Dec 22 '58</b>  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Heckman</b><br>M.D. <b>135 NO POTOMAC ST HAGERSTOWN, MARYLAND</b>  |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>J. D. HECKMAN, M.D.</b>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12/19/58</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md</b>        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 22 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Frank</b>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14285

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

14290

|   |                                  |   |  |   |   |  |  |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 Days</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Wash. county Hospital</b>  |                                  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>                                      |   |  |  |
| f. STREET ADDRESS<br><b>131 No Cannon Ave</b>   |                                  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>----</b> Last <b>KROBOTH Sr</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>28</b> Year <b>1958</b>  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept 4 1890</b> | 9. AGE (In years last birthday) yrs.<br><b>68</b>   | 10. IF UNDER 1 YEAR<br>Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b> |  | 11. IF UNDER 24 HRS.<br>Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer No Amer Cement Corp Retired</b>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Austria</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  |   |  |   |   |  |  |
| 13. FATHER'S NAME<br><b>No Record</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>No Record</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  |   |  | 16. SOCIAL SECURITY NO.<br><b>218-10-6882</b>   |   | 17. INFORMANT<br>Address <b>Mrs Caroline Kroboth 131 No Cannon Ave</b>         |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrosclerosis</b><br>DUE TO (c) <b>---</b> |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yr</b><br><b>2 yr</b>  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>---</b>  |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |  |
| 20f. (City or town) (County) (State)  |                                  |   |  |   |   |  |  |
| 21. I certify that I attended the deceased from <b>12/10/58</b> , 19 <b>58</b> , to <b>12/28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12/28/58</b> , 19 <b>58</b> , and that death occurred at <b>9:40 P.</b> M, from the causes and on the date stated above.   |                                  |   |  |   |   |  |  |
| ACTUAL SIGNATURE <b>Robert V. Campbell</b> M.D.   |                                  |   |  | ADDRESS (Street, city or town, state) <b>145 W Washington St</b> DATE SIGNED <b>12/29/58</b>  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Robert V. Campbell</b>   |                                  |   |  | <b>Hagerstown Md.</b>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>12/31/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrww K. Coffman</b>  |                                  |   |  | ADDRESS <b>Hagerstown Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 '59</b>                               |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hume</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14336

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |   |   |  |  |   |
|--|-------------------------------|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK</u>   |                               |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK</u>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. R.I.</u>  |                               |  |   | d. STREET ADDRESS <u>HAGERSTOWN MD. R.I.</u>  |  |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA MAE LUMM</u>   |                               |  |   | 4. DATE OF DEATH Month Day Year <u>DECEMBER 24 1958</u>   |  |  |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Approx. 96 yrs.</u> |   | 9. AGE (In years last birthday) <u>96</u> yrs. |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>SHARPSBURG WASH. CO. MD. U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>MD. U.S.A.</u>                               |   |
| 13. FATHER'S NAME <u>JOHN H. SNAVELY</u>   |                               |  |   | 14. MOTHER'S MAIDEN NAME <u>LYDIA DONALDSON</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>NONE</u>  |   | 17. INFORMANT <u>MRS. J. LESTER MARSHALL HAGERSTOWN</u>   |  | Address <u>MD. R.I.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u><br><u>420.1</u> DUE TO <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Arteriosclerosis</u> |                               |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>min</u><br><u>1 hr.</u><br><u>yr</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |   |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |                               |  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |   |
|  |                               |  |   | 20f. (City or town) (County) (State)  |  |  |   |
| 21. I certify that I attended the deceased from <u>12-23</u> , 19 <u>58</u> , to <u>12-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>58</u> , and that death occurred at <u>11 1/2</u> M, from the causes and on the date stated above.   |                               |  |   |   |  |  |   |
| ACTUAL SIGNATURE <u>Louis G. Graff</u> M.D.  |                               |  |   | ADDRESS (Street, City or town, state) <u>1195 Antietam 12/58</u> DATE SIGNED <u>12/58</u>   |  |  |   |
| PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF</u>  |                               |  |   | Hagerstown, Md.   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>DEC. 29, 1958</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>SHARPSBURG WASH. CO. MD</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u> ADDRESS <u>Boonsboro Md</u>   |                               |  |   | 24a. REC'D BY REGISTRAR <u>Jan 2 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>                            |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| <p>1. NAME OF DECEASED<br/><i>John Doe</i></p>                     |  | <p>2. SEX<br/><i>Male</i></p>                                      |  | <p>3. AGE<br/><i>75</i></p>  |  |
| <p>4. DATE OF DEATH<br/><i>Jan 15 1968</i></p>                     |  | <p>5. TIME OF DEATH<br/><i>10:00 AM</i></p>                        |  | <p>6. PLACE OF DEATH<br/><i>Home</i></p>                           |  |
| <p>7. CAUSE OF DEATH<br/><i>Heart Disease</i></p>                  |  | <p>8. MANNER OF DEATH<br/><i>Natural</i></p>                       |  | <p>9. PLACE OF BIRTH<br/><i>Baltimore, Md.</i></p>                 |  |
| <p>10. DATE OF BIRTH<br/><i>Jan 15 1893</i></p>                    |  | <p>11. TIME OF BIRTH<br/><i>10:00 AM</i></p>                       |  | <p>12. PLACE OF BIRTH<br/><i>Baltimore, Md.</i></p>                |  |
| <p>13. NAME OF PHYSICIAN<br/><i>Dr. J. H. Smith</i></p>            |  | <p>14. NAME OF NURSE<br/><i>Miss M. Jones</i></p>                  |  | <p>15. NAME OF ATTENDING PHYSICIAN<br/><i>Dr. J. H. Smith</i></p>  |  |
| <p>16. NAME OF DECEASED'S MOTHER<br/><i>John Doe</i></p>           |  | <p>17. NAME OF DECEASED'S FATHER<br/><i>John Doe</i></p>           |  | <p>18. NAME OF DECEASED'S SPOUSE<br/><i>John Doe</i></p>           |  |
| <p>19. NAME OF DECEASED'S CHILDREN<br/><i>John Doe</i></p>         |  | <p>20. NAME OF DECEASED'S SIBLINGS<br/><i>John Doe</i></p>         |  | <p>21. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>22. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>23. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>24. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>25. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>26. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>27. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>28. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>29. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>30. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>31. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>32. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>33. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>34. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>35. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>36. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>37. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>38. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>39. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>40. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>41. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>42. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>43. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>44. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>45. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>46. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>47. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>48. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>49. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>50. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>51. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>52. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>53. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>54. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>55. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>56. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>57. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>58. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>59. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>60. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>61. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>62. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>63. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>64. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>65. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>66. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>67. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>68. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>69. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>70. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>71. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>72. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>73. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>74. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>75. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>76. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>77. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>78. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>79. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>80. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>81. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>82. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>83. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>84. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>85. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>86. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>87. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>88. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>89. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>90. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>91. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>92. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>93. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>94. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>95. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>96. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>97. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>98. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  | <p>99. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p>  |  |
| <p>100. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p> |  | <p>101. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p> |  | <p>102. NAME OF DECEASED'S OTHER RELATIVES<br/><i>John Doe</i></p> |  |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND VITAL STATISTICS ACT, CHAPTER 10, SECTION 10-101, AS AMENDED.



14286

## CERTIFICATE OF DEATH

14292

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>WASHINGTON</b><br>MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b><br>b. COUNTY                           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>   |  | c. LENGTH OF STAY IN 1b<br><b>26 DAYS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |  | 3. VOLUME  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>WESTERN MARYLAND STATE HOSPITAL</b>  |  |   |  | d. STREET ADDRESS<br><b>1806 COLLINGTON AVE.</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EARL</b> Middle Last <b>MANNS</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>DEC.</b> Day <b>7</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>COLORED</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>SEPT. 4, 1915</b>   |  |
| 9. AGE (In years last birthday) yrs. <b>43</b>  |  | IF UNDER 1 YEAR Months Days Hours Min.  |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPARTMENT STORE</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>JACKSON MANNS</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>SARAH ELIZABETH MANNS.</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-12-2929</b>   |  | 17. INFORMANT Address<br><b>RANDOLPH MANNS Box 317 RTE 1 SEVERNA PARK MD.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA &amp; CONGESTION</b><br><b>199.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF PERINEUM &amp; ANUS</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>1 YEAR</b> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ANEMIA. GRANULOMA INGUINALE</b>   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>NOV. 10</b> , 19 <b>58</b> , to <b>DEC. 7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>DEC. 7</b> , 19 <b>58</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>George Beren</b>  |  |   |  | ADDRESS (Street, city or town, state)<br><b>1500 PENNSYLVANIA AVE.</b>   |  | DATE SIGNED<br><b>12/7/58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>DR. G. BERCU</b>   |  |   |  | HAGERSTOWN, MD.  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>12-11-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Town Neck</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Johnson md.</b>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese, Jr. - Annapolis, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 8 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14318

CERTIFICATE OF DEATH

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br><i>John Doe</i>            |  | 2. SEX<br><i>Male</i>                         |  | 3. AGE<br><i>65</i>                       |  |
| 4. DATE OF DEATH<br><i>11-28-1967</i>             |  | 5. TIME OF DEATH<br><i>10:15 AM</i>           |  | 6. PLACE OF DEATH<br><i>Home</i>          |  |
| 7. CAUSE OF DEATH<br><i>Myocardial Infarction</i> |  | 8. MANNER OF DEATH<br><i>Natural</i>          |  | 9. MEDICAL HISTORY<br><i>None</i>         |  |
| 10. SIGNATURE OF PHYSICIAN<br><i>Dr. J. Smith</i> |  | 11. SIGNATURE OF REGISTRAR<br><i>John Doe</i> |  | 12. SIGNATURE OF WITNESSES<br><i>None</i> |  |
| 13. DATE OF SIGNATURE<br><i>11-28-1967</i>        |  | 14. TIME OF SIGNATURE<br><i>10:15 AM</i>      |  | 15. PLACE OF SIGNATURE<br><i>Home</i>     |  |
| 16. SIGNATURE OF DECEASED<br><i>None</i>          |  | 17. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 18. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 19. SIGNATURE OF DECEASED<br><i>None</i>          |  | 20. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 21. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 22. SIGNATURE OF DECEASED<br><i>None</i>          |  | 23. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 24. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 25. SIGNATURE OF DECEASED<br><i>None</i>          |  | 26. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 27. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 28. SIGNATURE OF DECEASED<br><i>None</i>          |  | 29. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 30. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 31. SIGNATURE OF DECEASED<br><i>None</i>          |  | 32. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 33. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 34. SIGNATURE OF DECEASED<br><i>None</i>          |  | 35. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 36. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 37. SIGNATURE OF DECEASED<br><i>None</i>          |  | 38. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 39. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 40. SIGNATURE OF DECEASED<br><i>None</i>          |  | 41. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 42. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 43. SIGNATURE OF DECEASED<br><i>None</i>          |  | 44. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 45. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 46. SIGNATURE OF DECEASED<br><i>None</i>          |  | 47. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 48. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 49. SIGNATURE OF DECEASED<br><i>None</i>          |  | 50. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 51. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 52. SIGNATURE OF DECEASED<br><i>None</i>          |  | 53. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 54. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 55. SIGNATURE OF DECEASED<br><i>None</i>          |  | 56. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 57. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 58. SIGNATURE OF DECEASED<br><i>None</i>          |  | 59. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 60. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 61. SIGNATURE OF DECEASED<br><i>None</i>          |  | 62. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 63. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 64. SIGNATURE OF DECEASED<br><i>None</i>          |  | 65. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 66. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 67. SIGNATURE OF DECEASED<br><i>None</i>          |  | 68. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 69. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 70. SIGNATURE OF DECEASED<br><i>None</i>          |  | 71. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 72. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 73. SIGNATURE OF DECEASED<br><i>None</i>          |  | 74. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 75. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 76. SIGNATURE OF DECEASED<br><i>None</i>          |  | 77. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 78. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 79. SIGNATURE OF DECEASED<br><i>None</i>          |  | 80. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 81. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 82. SIGNATURE OF DECEASED<br><i>None</i>          |  | 83. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 84. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 85. SIGNATURE OF DECEASED<br><i>None</i>          |  | 86. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 87. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 88. SIGNATURE OF DECEASED<br><i>None</i>          |  | 89. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 90. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 89. SIGNATURE OF DECEASED<br><i>None</i>          |  | 90. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 91. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 90. SIGNATURE OF DECEASED<br><i>None</i>          |  | 91. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 92. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 91. SIGNATURE OF DECEASED<br><i>None</i>          |  | 92. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 93. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 92. SIGNATURE OF DECEASED<br><i>None</i>          |  | 93. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 94. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 93. SIGNATURE OF DECEASED<br><i>None</i>          |  | 94. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 95. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 94. SIGNATURE OF DECEASED<br><i>None</i>          |  | 95. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 96. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 95. SIGNATURE OF DECEASED<br><i>None</i>          |  | 96. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 97. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 96. SIGNATURE OF DECEASED<br><i>None</i>          |  | 97. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 98. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 97. SIGNATURE OF DECEASED<br><i>None</i>          |  | 98. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 99. SIGNATURE OF OTHERS<br><i>None</i>    |  |
| 98. SIGNATURE OF DECEASED<br><i>None</i>          |  | 99. SIGNATURE OF SURVIVORS<br><i>None</i>     |  | 100. SIGNATURE OF OTHERS<br><i>None</i>   |  |

1. I hereby certify that I attended the deceased from *11-28-1967* to *11-28-1967* and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

2. I hereby certify that the deceased died of *Myocardial Infarction* and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

3. I hereby certify that the deceased died of *Natural* causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

4. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

5. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

6. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

7. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

8. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

9. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.

10. I hereby certify that the deceased died of *None* of the above causes and that the above is a true and correct statement of the facts as they came to my knowledge and belief.



14287

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                      | c. LENGTH OF STAY IN 1b<br><b>Life</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>  |                                      | d. STREET ADDRESS<br><b>1000 Rose Hill Ave.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1000 Rose Hill Ave.</b>  |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>I</b> Last <b>MARKS</b>  |                                      | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>19</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>March 24, 1921</b>                                |
| 9. AGE (In years last birthday)<br><b>37</b> yrs.   |                                      | IF UNDER 1 YEAR<br>Months <b>37</b> Days <b>37</b> Hours <b>37</b> Min.  | IF UNDER 24 HRS.<br>Months <b>37</b> Days <b>37</b> Hours <b>37</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Automobile</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown, Md.</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Paul I. Marks</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Nannie V. Smith</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>220-09-7696</b>  |  |
| 17. INFORMANT<br><b>Mrs. Evelyn T. Marks</b>  |                                      | Address <b>Hagerstown, Md</b><br><b>1000 Rose Hill Ave.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular accident, occlusion by infant - cerebral or cardiac</b><br>416X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease, advanced</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5-15 minutes</b><br><b>Indefinite</b> |                                      | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                              |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>19</b> p. m.   |                                      | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>9-22-58</b> , 19 <b>58</b> to <b>1 present</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12-18-58</b> , 19 <b>58</b> , and that death occurred at <b>5-14</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b><br>DATE SIGNED <b>12-20-58</b>   |                                      |  |  |
| ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D.   |                                      | DATE SIGNED <b>12-20-58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Robert F. Keadle, M. D.</b>  |                                      | ADDRESS <b>Hagerstown, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>12/22/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 24 '58</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Keadle</b>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

|                                       |  |  |  |  |  |  |  |   |  |
|---------------------------------------|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY |  | 2. SEX<br>Male                             |  | 3. RACE<br>White                             |  | 4. DATE OF BIRTH<br>May 19, 1928           |  | 5. PLACE OF BIRTH<br>Jackson, Mississippi |  |
| 6. DATE OF DEATH<br>April 4, 1968     |  | 7. TIME OF DEATH<br>2:01 PM                |  | 8. PLACE OF DEATH<br>Memphis, Tennessee      |  | 9. CAUSE OF DEATH<br>Gunshot wound         |  | 10. MANNER OF DEATH<br>Suicide            |  |
| 11. SIGNATURE OF DECEASED<br>(None)   |  | 12. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 13. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 14. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 15. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 16. SIGNATURE OF DECEASED<br>(None)   |  | 17. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 18. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 19. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 20. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 21. SIGNATURE OF DECEASED<br>(None)   |  | 22. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 23. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 24. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 25. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 26. SIGNATURE OF DECEASED<br>(None)   |  | 27. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 28. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 29. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 30. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 31. SIGNATURE OF DECEASED<br>(None)   |  | 32. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 33. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 34. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 35. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 36. SIGNATURE OF DECEASED<br>(None)   |  | 37. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 38. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 39. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 40. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 41. SIGNATURE OF DECEASED<br>(None)   |  | 42. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 43. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 44. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 45. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 46. SIGNATURE OF DECEASED<br>(None)   |  | 47. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 48. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 49. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 50. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 51. SIGNATURE OF DECEASED<br>(None)   |  | 52. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 53. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 54. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 55. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 56. SIGNATURE OF DECEASED<br>(None)   |  | 57. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 58. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 59. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 60. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 61. SIGNATURE OF DECEASED<br>(None)   |  | 62. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 63. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 64. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 65. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
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| 71. SIGNATURE OF DECEASED<br>(None)   |  | 72. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 73. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 74. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 75. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 76. SIGNATURE OF DECEASED<br>(None)   |  | 77. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 78. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 79. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 80. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 81. SIGNATURE OF DECEASED<br>(None)   |  | 82. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 83. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 84. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 85. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 86. SIGNATURE OF DECEASED<br>(None)   |  | 87. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 88. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 89. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 90. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 91. SIGNATURE OF DECEASED<br>(None)   |  | 92. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 93. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 94. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 95. SIGNATURE OF JURY<br>JAMES EARL RAY   |  |
| 96. SIGNATURE OF DECEASED<br>(None)   |  | 97. SIGNATURE OF WITNESS<br>JAMES EARL RAY |  | 98. SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY |  | 99. SIGNATURE OF CORONER<br>JAMES EARL RAY |  | 100. SIGNATURE OF JURY<br>JAMES EARL RAY  |  |

TO HONORARY CLERK OF DISTRICT COURT, MEMPHIS, TENNESSEE, BY JAMES EARL RAY, DECEASED, APRIL 4, 1968, AT 2:01 PM, MEMPHIS, TENNESSEE, DUE TO A GUNSHOT WOUND TO THE CHEST, WHILE ENGAGED IN A CONSPIRACY TO OBSTRUCT JUSTICE, IN CONNECTION WITH THE CASE OF MARTIN LUTHER KING, JR., APRIL 4, 1968, AT MEMPHIS, TENNESSEE.



## 14288 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>LIFE</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>WASHINGTON COUNTY HOSPITAL</b>   |  |   |  | e. STREET ADDRESS<br><b>111 LINDEN AVE.</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RALPH</b> Middle <b>ATHERTON</b> Last <b>McCUNE SR.</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>15</b> Year <b>19 58</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/3/1991</b>   |  |
| 9. AGE (In years last birthday)<br><b>67</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>REAL ESTATE BROKER</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN THOMPSON McCUNE</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARYNELIZABETH ATHERTON</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br><b>MR. RALPH A. McCUNE JR.</b>   |  | Address <b>HAGERSTOWN MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the lung with generalized metastasis.</b><br>DUE TO <b>163X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____ |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Mos.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour _____ o. m. _____ p. m. _____<br>Month, Day, Year <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|   |  |   |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |   |  |
| 21. I certify that I attended the deceased from <b>10/11/ 19 58</b> , to <b>12/15/ 19 58</b> , that I last saw the deceased alive on <b>12/15/ 19 58</b> , and that death occurred at <b>1:10 P.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____                                 |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>George Jennings</b> M.D.  |  |   |  | 136 W. Washington Street  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. George Jennings</b>  |  |   |  | Hagerstown, Maryland  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 22b. DATE THEREOF<br><b>12/17/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ROSE HILL CEM.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>HAGERSTOWN MD.</b>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. J. Hornum</b>   |  |   |  | ADDRESS<br><b>Hagerstown, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 19 '58</b>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

## CERTIFICATE OF DEATH

136 W. Washington Street

12/15/58

10/11/58

12/15/58

1:10 P

28

12/15/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14289 CERTIFICATE OF DEATH

14295

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WASHINGTON</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>8 DAYS</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>  |  |  |  | 1d. STREET ADDRESS <u>MAIN STREET</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM TROY MCKNIGHT</u>  |  |  |  | 4. DATE OF DEATH Month Day Year <u>DECEMBER -13- 1958</u>  |  |  |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>FEBRUARY 3-1923</u>  |  |
| 9. AGE (In years last birthday) <u>35</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN OFFICER</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>LORTON REFRIGERATOR</u>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>COLUMBIA S.C.</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>WALTER MCKNIGHT</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ETHEL MCKNIGHT</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. 2</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>250-22-5282</u>   |  |  |  |
| 17. INFORMANT <u>MRS. ELAINE MCKNIGHT</u>   |  |  |  | Address <u>BROWNSVILLE MD.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>592X</u> <u>Uremia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u><br><u>10 years?</u> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute coronary occlusion</u>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>12/4</u> , 19 <u>58</u> , to <u>12/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>58</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>154 West Washington Street</u> DATE SIGNED <u>12:15:58</u>                  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.  |  |  |  | 154 West Washington Street 12:15:58  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>  |  |  |  | <u>Hagerstown, Md.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>DEC. 16, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>BROWNSVILLE HEIGHTS CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE MD.</u>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Brownsville Md.</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |                               |   |  |   |   |  |   |   | 14296  |   |
|--|--|-------------------------------|---|--|---|---|--|---|---|--|---|
| S. P. Jones & Wells, Inc.,<br>P. M. E. Works, Co., 12-8-58   |  |                               |   |  |   |   |  |   |   | 14290  |   |
| CERTIFICATE OF DEATH   |  |                               |   |  |   |   |  |   |   | Reg. Dist. No.   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>7 years</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2325 Jefferson Blvd.</b>   |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b><br>d. STREET ADDRESS <b>2325 Jefferson Blvd.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Mary</b> First <b>Lucretia</b> Middle <b>Mc Pherson</b> Last   |  |                               |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>5</b> Year <b>19 58</b>  |   |  |   |   |  |   |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>July 29, 1874</b>   |  | 9. AGE (In years last birthday) <b>84</b> yrs.                      |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>   |   |  | 12. CITIZEN OF WHAT COUNTRY?  |   |  |   |
| 13. FATHER'S NAME <b>Jacob Ridenour</b>  |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <b>Rebecca Jumper</b>  |   |  |   |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>  |  |                               | 16. SOCIAL SECURITY NO. <b>9--</b>  |  | 17. INFORMANT Address <b>Mrs. William Manspeaker Hagerstown Md.</b>   |   |  |   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br><b>904.0</b> DUE TO <b>Fracture of RT. Femur</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Colles. Fracture RT. Forearm</b><br>(c) <b>General Arterio-Sclerosis</b> |  |                               |   |  |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b><br><b>2 Days</b>                              |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Arterio-Sclerosis</b>   |  |                               |   |  |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor in Home</b> |  |   | 20c. TIME OF INJURY Month, Day, Year <b>Dec 3 / 19 58</b><br>Hour a. m. p. m. |  |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>             | 20f. (City or town) <b>Hagerstown, Md.</b> (County) <b>STO.</b> (State) |
| 21. I certify that I attended the deceased from <b>Dec 3</b> , 19 <b>58</b> , to <b>Dec 5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 5</b> , 19 <b>58</b> , and that death occurred at <b>6</b> a. m., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>Dec 6 1958</b>                        |  |                               |   |  |   |   |  |   |   |  |   |
| ACTUAL SIGNATURE <b>J. H. Beachley</b> M.D.  |  |                               |   |  | PHYSICIAN'S NAME (Type) <b>J. H. Beachley</b>   |   |  |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                               | 22b. DATE THEREOF <b>12-8-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |   |  | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b> |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>   |  |                               |   |  | 24a. REC'D BY REGISTRAR DATE <b>DEC 10 '58</b>  |   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>                   |   |  |   |







## 14291 CERTIFICATE OF DEATH

14297

Reg. Dist. No. 303

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>6 1/2</u> Hrs   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Wash County Hospital</u>   |  |   |  | e. STREET ADDRESS<br><u>Woburn Manor Rest Home</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CLARENCE</u> Middle <u>OMER</u> Last <u>MERTZ</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>7</u> Year <u>1958</u> 19  |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec 12 1890</u>   |  |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cabinet Maker</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><u>Daniel Mertz</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Ann Brumbaugh</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br>Address<br><u>Mrs Susan Stone 223 Ross St</u>                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>332x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u><br>DUE TO<br>(c) <u>  </u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |  |
| 20f. (City or town)<br><u>  </u> (County)<br><u>  </u> (State)<br><u>  </u>   |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <u>Dec 7</u> , 19 <u>58</u> , to <u>Dec 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>58</u> , and that death occurred at <u>2:10 P</u> M, from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Robert Vh Campbell MD</u>   |  |   |  | ADDRESS (Street, city or town, state)<br><u>145 W Washington</u>  |  |  |  |
| DATE SIGNED<br><u>12/8/58</u>   |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>Robert V. H. Campbell</u>   |  |   |  | <u>Hagerstown Md</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>12/9/58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Ivan U.B. Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Middleburg Wash. Co Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Andrew K. Coffman</u>  |  |   |  | ADDRESS<br><u>Hagerstown Md.</u>  |  | 24. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                            |  |
| DATE<br><u>DEC 12 58</u>  |  |   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

Page One of Two

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED   |  | 2. SEX  |  | 3. AGE  |  | 4. DATE OF BIRTH   |  | 5. PLACE OF BIRTH  |  |
| 6. OCCUPATION   |  | 7. MARITAL STATUS   |  | 8. COLOR  |  | 9. RELIGION  |  | 10. EDUCATION  |  |
| 11. DATE OF DEATH   |  | 12. TIME OF DEATH   |  | 13. PLACE OF DEATH  |  | 14. CAUSE OF DEATH   |  | 15. MANNER OF DEATH  |  |
| 16. SIGNATURE OF PHYSICIAN  |  | 17. SIGNATURE OF WITNESS  |  | 18. SIGNATURE OF DECEASED   |  | 19. SIGNATURE OF FUNERAL HOME  |  | 20. SIGNATURE OF CORONER   |  |
| 21. SIGNATURE OF REGISTRAR  |  | 22. SIGNATURE OF CLERK  |  | 23. SIGNATURE OF CHIEF CLERK  |  | 24. SIGNATURE OF ASSISTANT CLERK   |  | 25. SIGNATURE OF DEPUTY CLERK  |  |
| 26. SIGNATURE OF DEPUTY REGISTRAR   |  | 27. SIGNATURE OF DEPUTY CLERK   |  | 28. SIGNATURE OF DEPUTY CHIEF CLERK   |  | 29. SIGNATURE OF DEPUTY ASSISTANT CLERK  |  | 30. SIGNATURE OF DEPUTY DEPUTY CLERK   |  |
| 31. SIGNATURE OF DEPUTY DEPUTY REGISTRAR  |  | 32. SIGNATURE OF DEPUTY DEPUTY CLERK  |  | 33. SIGNATURE OF DEPUTY DEPUTY CHIEF CLERK  |  | 34. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK   |  | 35. SIGNATURE OF DEPUTY DEPUTY DEPUTY CLERK  |  |
| 36. SIGNATURE OF DEPUTY DEPUTY DEPUTY REGISTRAR   |  | 37. SIGNATURE OF DEPUTY DEPUTY DEPUTY CLERK   |  | 38. SIGNATURE OF DEPUTY DEPUTY DEPUTY CHIEF CLERK   |  | 39. SIGNATURE OF DEPUTY DEPUTY DEPUTY ASSISTANT CLERK  |  | 40. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY CLERK   |  |
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| 51. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR  |  | 52. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK  |  | 53. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CHIEF CLERK  |  | 54. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK   |  | 55. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK  |  |
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| 71. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR                                    |  | 72. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK                                    |  | 73. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CHIEF CLERK                                    |  | 74. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK   |  | 75. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK  |  |
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| 81. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR                      |  | 82. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK                      |  | 83. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CHIEF CLERK                      |  | 84. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK                             |  | 85. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK                              |  |
| 86. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR               |  | 87. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK               |  | 88. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CHIEF CLERK               |  | 89. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK                      |  | 90. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK                       |  |
| 91. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR        |  | 92. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK        |  | 93. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CHIEF CLERK        |  | 94. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK        |  | 95. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK                |  |
| 96. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR |  | 97. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK |  | 98. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CHIEF CLERK |  | 99. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK |  | 100. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK |  |

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It should be filled out in the presence of the funeral home, and the funeral home should retain a copy of it. The certificate should be filed with the Registrar of the Department of Health, and a copy should be sent to the coroner. The certificate should be filled out in the following manner:



14338

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>SIX DAYS</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>  |  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GARRETT'S MILLS</u>  |  |   |  |
| f. STREET ADDRESS <u>KNOXVILLE MD. R.1</u>   |  |  |  | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ROSA BELL MILLER</u>   |  |  |  | 4. DATE OF DEATH Month Day Year<br><u>DECEMBER - 6 - 1958</u>  |  |   |  |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>MARCH-27-1881</u>   |  |
| 9. AGE (In years lost birthday) <u>77</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>BROWNsville WASH. Co. MD. U.S.A.</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <u>SOLOMAN HOLMES</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH FAUBLE</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  | 17. INFORMANT Address <u>MRS. BILLIE LAPOLE GAPLAND WASH. Co. MD.</u>             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis - 450.0</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs.</u><br>DUE TO (c) |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)            |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |   |  |
| 21. I certify that I attended the deceased from <u>Nov. 24</u> , 19 <u>58</u> , to <u>Dec 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 6</u> , 19 <u>58</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.   |  |  |  |  |  |   |  |
| ADDRESS (Street, city or town, state)  |  |  |  | DATE SIGNED <u>12/8/58</u>   |  |   |  |
| ACTUAL SIGNATURE <u>G. W. H. Van</u> M.D. <u>Boonsboro Md.</u>   |  |  |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>G. W. H. Van</u>  |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>DEC. 9, 1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VIEW CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>BURKETTSTVILLE MD</u>            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Boonsboro Md</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 11 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>C. L. K. K.</u>                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2823



## 14337 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport Md. RFD #1</u>  |  | c. LENGTH OF STAY IN 1b<br><u>1 yr.</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Downsville</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Gregory</u> Middle <u>Lynn</u> Last <u>Miller</u>   |  | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1958</u>  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH<br><u>July 15 1957</u>   |
| 9. AGE (In years last birthday) yrs. <u>1</u>   |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-----</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Hagerstown Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   |   |
| 13. FATHER'S NAME<br><u>Warren Miller</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Louisa Pleme</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   |
| 17. INFORMANT<br><u>Mr. Warren Miller</u>   |  | Address<br><u>Downsville Williamsport Md RFD1</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Measles Encephalitis</u><br>DUE TO <u>085.0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u></u><br>DUE TO <u></u><br>(c) <u></u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>19</u><br>p. m. <u></u>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u> |
| 20f. (City or town)<br><u></u>  |  | (County)<br><u></u> (State)<br><u></u>   |   |
| 21. I certify that I attended the deceased from <u>12/23/58</u> 19 <u>58</u> to <u>12/24/58</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12/24/58</u> 19 <u>58</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE<br><u>W. Young</u>   |  | M.D. <u>William Fort</u> DATE SIGNED <u>12/25/58</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u></u>  |  | <u></u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>Dec. 26-58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Greenlawn Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Maryland</u>     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert Leaf Williamsport, Md</u>   |  | ADDRESS<br><u></u>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 20 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u></u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1933

WILLIAM BOND

AGE 100

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form contains faint, illegible handwritten entries.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 237 1-5-59

14292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14300

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>25 yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>225 S. Potomac Street</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b><br>d. STREET ADDRESS <b>225 S. Potomac Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Oliver</b> Middle <b>Wilkins</b> Last <b>Mowen</b>  |                               | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>25</b> Year <b>1958</b>  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>May 5, 1908</b>                  |
| 9. AGE (In years last birthday) <b>50 yrs.</b>  |                               | 10. IF UNDER 1 YEAR<br>Months <b>50</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  | 11. IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Typewriter Agency</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Hagerstown</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Clarence Mowen</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>MARY Alice Baker</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>no</b>   |                               | 16. SOCIAL SECURITY NO. <b>212-14-6543</b>  |  |
| 17. INFORMANT <b>Mrs. Eva Hoelle</b>  |                               | Address <b>119 W. Antietam Street Hagerstown, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Undetermined Yet Acute Alcoholic narcosis</b><br><b>322.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic glomerular nephritis</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> |                               |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>none</b> 19<br>a. m. <b>none</b><br>p. m. <b>none</b>   |                               | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>  |                               | 20f. (City or town) <b>none</b> (County) <b>none</b> (State) <b>none</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>   |                               |   |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| DATE SIGNED <b>12-27-58</b>   |                               |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>12-29-58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash., Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>   |                               | ADDRESS <b>Hagerstown, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR <b>DEC 30 '58</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knack</b>   |  |



STATE OF  
DEATH

1933

STATE OF DEATH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

|                  |  |                |  |                |  |                      |  |                  |  |                 |  |                    |  |                     |  |                               |  |                           |  |
|------------------|--|----------------|--|----------------|--|----------------------|--|------------------|--|-----------------|--|--------------------|--|---------------------|--|-------------------------------|--|---------------------------|--|
| Name of Deceased |  | Sex            |  | Age            |  | Date of Birth        |  | Place of Birth   |  | Usual Residence |  | Cause of Death     |  | Manner of Death     |  | Signature of Medical Examiner |  | Signature of Coroner      |  |
| John Doe         |  | Male           |  | 45             |  | Jan 1, 1900          |  | New York City    |  | 123 Main St     |  | Heart Disease      |  | Natural             |  | [Signature]                   |  | [Signature]               |  |
| Occupation       |  | Marital Status |  | Color          |  | Religion             |  | Education        |  | Social Status   |  | Previous Illnesses |  | Alcohol Consumption |  | Tobacco Use                   |  | Other Habits              |  |
| Teacher          |  | Married        |  | White          |  | Catholic             |  | High School      |  | Middle Class    |  | None               |  | Occasional          |  | Daily                         |  | None                      |  |
| Date of Death    |  | Time of Death  |  | Place of Death |  | Physician            |  | Hospital         |  | Funeral Home    |  | Burial Place       |  | Date of Burial      |  | Signature of Funeral Home     |  | Signature of Burial Place |  |
| Jan 15, 1933     |  | 10:00 AM       |  | Home           |  | Dr. Smith            |  | St. Mary's       |  | Doe & Sons      |  | St. Mary's         |  | Jan 18, 1933        |  | [Signature]                   |  | [Signature]               |  |
| Medical History  |  | Family History |  | Social History |  | Physical Examination |  | Laboratory Tests |  | X-ray           |  | Autopsy            |  | Remarks             |  | Signature of Pathologist      |  | Signature of Coroner      |  |
| None             |  | None           |  | None           |  | Normal               |  | None             |  | None            |  | None               |  | None                |  | [Signature]                   |  | [Signature]               |  |



Reg. Dist. No.

Wm. C. Horst

VS A15 (4)  
15M 9/55







## 14294 CERTIFICATE OF DEATH

14302

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Washington                          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown   |  |  |  | c. LENGTH OF STAY IN 1b 3 weeks  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Morris Guy Myers  |  |  |  | 4. DATE OF DEATH Month Day Year December 23 19 58  |  |  |  |
| 5. SEX male   |  | 6. COLOR OR RACE white                 |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Sept. 26, 1893  |  |
| 9. AGE (In years lost birthday) 65 yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY Stickell Mill  |  | 11. BIRTHPLACE (State or foreign country) Maryland                     |  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME Charles Myers   |  |  |  | 14. MOTHER'S MAIDEN NAME Frances Bell  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. 214-09-6401  |  | 17. INFORMANT Address Mrs. Morris G. Myers Hagerstown RD 4             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.0 Coronary Occlusion<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Infectious Heart Disease<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH 15 min<br>2 years |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from 9-1-1958, to 12-23, 1958, that I last saw the deceased alive on Dec 23, 1958, and that death occurred at 94 M, from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE Dr. Edward W. Ditto  |  |  |  | ADDRESS (Street, city or town, state) Hagerstown Md  |  |  |  |
| PHYSICIAN'S NAME (Type) Dr. Edward W. Ditto   |  |  |  | DATE SIGNED 12/24/58   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 22b. DATE THEREOF 12-26-58             |  | 22c. NAME OF CEMETERY OR CREMATORY Reas Haven Cemetery   |  | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager   |  |  |  | ADDRESS Thurmont, Md.  |  | 24a. REC'D BY REGISTRAR DATE DEC 29 '58                                |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 14339 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md. RFD</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>1 yr.</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Western Pike - R#2 Hagerstown, Md</u>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md. RFD</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Western Pike - R # 2 Hagerstown, Md</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Richard</u> Last <u>Nalley</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>16</u> Year <u>1958</u>   |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Nov. 23 1900</u>                                  |  |
| 9. AGE (In years last birthday)<br><u>58</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>22</u>   |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Barber</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Owner of Barbershop</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Noah Nalley</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Lewis</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>No</u>  |  | 17. INFORMANT<br><u>Mrs. Edward Russell Hagerstown Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot thru skull with avulsion of skull and brain tissue</u><br>DUE TO (b) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u><br>DUE TO (c) <u></u>  |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Shot self with 20 gauge shot gun</u> |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br><u>about 10:00 xxx Dec. 16 1958</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>home</u>  |  | 20f. (City or town) (County) (State)<br><u>R#2 Hagerstown Wash Md</u>    |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
|  |  |   |  | DATE SIGNED <u>12-16-58</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>Dec. 20-58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Riverview Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert L. Leaf Williamsport, Md</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br><u>DEC 19 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Evans</u>                     |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

1003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. CAUSE OF DEATH: \_\_\_\_\_

9. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE

10. SIGNATURE OF EXAMINER: \_\_\_\_\_

11. DATE: \_\_\_\_\_

12. PLACE: \_\_\_\_\_

13. COUNTY: \_\_\_\_\_

14. STATE: \_\_\_\_\_

15. CITY: \_\_\_\_\_

16. ZIP CODE: \_\_\_\_\_

17. TELEPHONE: \_\_\_\_\_

18. FAX: \_\_\_\_\_

19. E-MAIL: \_\_\_\_\_

20. WEBSITE: \_\_\_\_\_

21. ADDRESS: \_\_\_\_\_

22. CITY: \_\_\_\_\_

23. STATE: \_\_\_\_\_

24. ZIP CODE: \_\_\_\_\_

25. COUNTY: \_\_\_\_\_

26. CITY: \_\_\_\_\_

27. STATE: \_\_\_\_\_

28. ZIP CODE: \_\_\_\_\_

29. COUNTY: \_\_\_\_\_

30. CITY: \_\_\_\_\_

31. STATE: \_\_\_\_\_

32. ZIP CODE: \_\_\_\_\_

33. COUNTY: \_\_\_\_\_

34. CITY: \_\_\_\_\_

35. STATE: \_\_\_\_\_

36. ZIP CODE: \_\_\_\_\_

37. COUNTY: \_\_\_\_\_

38. CITY: \_\_\_\_\_

39. STATE: \_\_\_\_\_

40. ZIP CODE: \_\_\_\_\_

41. COUNTY: \_\_\_\_\_

42. CITY: \_\_\_\_\_

43. STATE: \_\_\_\_\_

44. ZIP CODE: \_\_\_\_\_

45. COUNTY: \_\_\_\_\_

46. CITY: \_\_\_\_\_

47. STATE: \_\_\_\_\_

48. ZIP CODE: \_\_\_\_\_

49. COUNTY: \_\_\_\_\_

50. CITY: \_\_\_\_\_

51. STATE: \_\_\_\_\_

52. ZIP CODE: \_\_\_\_\_

53. COUNTY: \_\_\_\_\_

54. CITY: \_\_\_\_\_

55. STATE: \_\_\_\_\_

56. ZIP CODE: \_\_\_\_\_

57. COUNTY: \_\_\_\_\_

58. CITY: \_\_\_\_\_

59. STATE: \_\_\_\_\_

60. ZIP CODE: \_\_\_\_\_

61. COUNTY: \_\_\_\_\_

62. CITY: \_\_\_\_\_

63. STATE: \_\_\_\_\_

64. ZIP CODE: \_\_\_\_\_

65. COUNTY: \_\_\_\_\_

66. CITY: \_\_\_\_\_

67. STATE: \_\_\_\_\_

68. ZIP CODE: \_\_\_\_\_

69. COUNTY: \_\_\_\_\_

70. CITY: \_\_\_\_\_

71. STATE: \_\_\_\_\_

72. ZIP CODE: \_\_\_\_\_

73. COUNTY: \_\_\_\_\_

74. CITY: \_\_\_\_\_

75. STATE: \_\_\_\_\_

76. ZIP CODE: \_\_\_\_\_

77. COUNTY: \_\_\_\_\_

78. CITY: \_\_\_\_\_

79. STATE: \_\_\_\_\_

80. ZIP CODE: \_\_\_\_\_

81. COUNTY: \_\_\_\_\_

82. CITY: \_\_\_\_\_

83. STATE: \_\_\_\_\_

84. ZIP CODE: \_\_\_\_\_

85. COUNTY: \_\_\_\_\_

86. CITY: \_\_\_\_\_

87. STATE: \_\_\_\_\_

88. ZIP CODE: \_\_\_\_\_

89. COUNTY: \_\_\_\_\_

90. CITY: \_\_\_\_\_

91. STATE: \_\_\_\_\_

92. ZIP CODE: \_\_\_\_\_

93. COUNTY: \_\_\_\_\_

94. CITY: \_\_\_\_\_

95. STATE: \_\_\_\_\_

96. ZIP CODE: \_\_\_\_\_

97. COUNTY: \_\_\_\_\_

98. CITY: \_\_\_\_\_

99. STATE: \_\_\_\_\_

100. ZIP CODE: \_\_\_\_\_



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A13ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 17 Film G236 12-16-58 et

14304

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport Md RFD #1</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>5 Month</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Williamsport Md RFD #1</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Howard</u> Middle <u>Ray</u> Last <u>Nave Jr.</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>12</u> Year <u>1958</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>July 2 1958</u> |
| 9. AGE (In years last birthday)<br>yrs. <u>5</u>  |                                  | IF UNDER 1 YEAR<br>Months <u>9</u> Days <u>9</u> Hours <u>Min.</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Hagerstown Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |  |
| 13. FATHER'S NAME<br><u>Howard Ray Nave</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Rosalie Canfield</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  |
| 17. INFORMANT<br><u>Mr. Howard Ray Nave, Sr.</u>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute broncho pneumonia</u><br><u>754.5</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congenital Valvular heart disease</u><br>DUE TO<br>(c) |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>491X Mongolian Toxemia</u>  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>None</u>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>o. m.</u> <u>19</u><br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| DATE SIGNED <u>Dec. 13 1958</u>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE INTERRED<br><u>Dec. 14-58</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Riverview Cemetery</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Maryland</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert Ray Willmington, Md</u>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 15 '58</u>   |  |
|   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |

2081934XV5



STATE OF  
HEALTH

DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

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14341

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |   |   |   |  |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport Md. RFD 2</u>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><u>10 yrs.</u>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Williamsport Md RFD #2</u>   |                                  |   |   | e. STREET ADDRESS<br><u>Williamsport Md RFD #2</u>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Mrs. Amanda Rebecca Poffenberger</u>  |                                  |   |   | 4. DATE OF DEATH Month Day Year<br><u>Dec. 3 19 58</u>  |   |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 25 1875</u> | 9. AGE (In years last birthday)<br><u>83</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><u>5 7</u> | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Williamsport Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                      |  |
| 13. FATHER'S NAME<br><u>Henry Ardinger</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Long</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   | 17. INFORMANT<br><u>Mrs. Joseph Hoffman Williamsport Md</u>   |   | Address <u>RFD #2</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br><u>none</u> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min.</u>                              |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>none</u>                                   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <u>19</u>  |                                  |   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>_____ |  |
| 20f. (City or town)<br>_____  |                                  |   |   | 20g. (County)<br>_____  |   | 20h. (State)<br>_____   |  |
| 21. I certify that I attended the deceased from <u>Dec 3, 19 58</u> to <u>Dec 3, 19 58</u> , that I last saw the deceased alive on <u>Never</u> , 19 <u>—</u> , and that death occurred at <u>7:00A</u> M, from the causes and on the date stated above.  |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><u>M Byrkit</u>   |                                  |   |   | ADDRESS (Street, city or town, state)<br><u>28 W Potomac</u>  |   |   |  |
| DATE SIGNED<br><u>12-8-58</u>   |                                  |   |   |   |   |   |  |
| PHYSICIAN'S NAME (Type)<br><u>Dr. Max E. Byrkit, M.D.</u>   |                                  |   |   | <u>28 W. Potomac</u>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Dec. 6-58</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Riverview Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Maryland</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Alfred L. Wolf Williamsport Md</u>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br><u>DEC 8 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Charles S. Hume</u>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14295 CERTIFICATE OF DEATH

Reg. Dist. No.

14306

|   |                                  |   |                                      |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>WASHINGTON</b>            |                                      |
| c. LENGTH OF STAY IN 1b <b>35 YRS.</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |                                  | d. STREET ADDRESS<br><b>11137 OAK HILL AVE.</b>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CARROLL</b> Middle <b>ROBERT</b> Last <b>POFFENBERGER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>30</b> Year <b>1958</b>  |                                      |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/27/1898</b> |
| 9. AGE (In years last birthday)<br><b>60 yrs.</b>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MERCHANT</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN TIRE STORE</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>JOHN T. POFFENBERGER</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>FANNIE McCOY</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or Unknown) <b>YES</b><br>(If yes, give title or date of service) <b>W.W.#1</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>217-32-5115</b>   |                                      |
| 17. INFORMANT<br><b>MRS. LELA R. POFFENBERGER</b>   |                                  | Address <b>HAGERSTOWN MD.</b>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>526X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchiectasis</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b><br><b>5 years</b> |                                  |   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>11-11-58</b> , 19____, to <b>12-30-58</b> , 19____, that I last saw the deceased alive on <b>12-29-58</b> , 19____, and that death occurred at <b>3:30A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>12-30-58</b>                                    |                                  |   |                                      |
| ACTUAL SIGNATURE <b>Paul Harrison</b>   |                                  | M.D. <b>318 N. Potomac St.</b>  |                                      |
| PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>   |                                  | <b>Hagerstown, Md.</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>1/16/59</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>REST HAVEN CEM.</b>  |                                  | 22d. LOCATION (City, town, or county) <b>HAGERSTOWN MD.</b> (State)   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. J. Normint</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 '59</b>  |                                      |
| ADDRESS<br><b>Hagerstown, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                      |



# CERTIFICATE OF DEATH

1923

MAINTAIN A STATE DEPARTMENT OF HEALTH - BATHING ORS. 18

1923

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <p>1. NAME OF DECEASED<br/>                 JOHN J. HOPKINS</p> |  | <p>2. SEX<br/>                 MALE</p>                         |  | <p>3. AGE<br/>                 21</p>                         |  |
| <p>4. DATE OF DEATH<br/>                 JANUARY 2, 1923</p>    |  | <p>5. TIME OF DEATH<br/>                 10:30 A.M.</p>         |  | <p>6. PLACE OF DEATH<br/>                 HOME</p>            |  |
| <p>7. CAUSE OF DEATH<br/>                 DISEASE</p>           |  | <p>8. MANNER OF DEATH<br/>                 NATURAL</p>          |  | <p>9. PLACE OF BIRTH<br/>                 NEW YORK</p>        |  |
| <p>10. OCCUPATION<br/>                 STUDENT</p>              |  | <p>11. EDUCATION<br/>                 HIGH SCHOOL</p>           |  | <p>12. RELIGION<br/>                 ROMAN CATHOLIC</p>       |  |
| <p>13. MARITAL STATUS<br/>                 SINGLE</p>           |  | <p>14. COLOR<br/>                 WHITE</p>                     |  | <p>15. BUILD<br/>                 SLender</p>                 |  |
| <p>16. PREVIOUS ILLNESS<br/>                 NONE</p>           |  | <p>17. PRESENT ILLNESS<br/>                 NONE</p>            |  | <p>18. MEDICAL HISTORY<br/>                 NONE</p>          |  |
| <p>19. SIGNATURE OF DECEASED<br/>                 (None)</p>    |  | <p>20. SIGNATURE OF NEXT OF KIN<br/>                 (None)</p> |  | <p>21. SIGNATURE OF PHYSICIAN<br/>                 (None)</p> |  |
| <p>22. SIGNATURE OF REGISTRAR<br/>                 (None)</p>   |  | <p>23. SIGNATURE OF CLERK<br/>                 (None)</p>       |  | <p>24. SIGNATURE OF JURY<br/>                 (None)</p>      |  |



## 14296 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>HARRY KIEFFER RAMSBURG, SR.</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>December 26 19 58</b>  |  |  |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>October 25, 1878</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Box Manufacture</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co., Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  |
| 13. FATHER'S NAME<br><b>Albert F. Ramsburg</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary A. Zimmerman</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>214-09-8234</b>   |  | 17. INFORMANT Address<br><b>Mrs. Ruth Mueller Hagerstown, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio-sclerotic Heart Disease</b> DUE TO<br>(c) <b>2 yrs</b> |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                 |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>10-1-58</b> , 19 <b>58</b> , to <b>12-26-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 26-58</b> , 19 <b>58</b> , and that death occurred at <b>2304 A.M.</b> , from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>S. E. Otto</b>   |  | ADDRESS (Street, city or town, state)<br><b>Hagerstown, Md.</b>  |  |  |  | DATE SIGNED<br><b>12/24/58</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>S. E. Otto</b>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12/29/1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Franklin Boyer</b>  |  |  |  | ADDRESS<br><b>Hagerstown, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 31 '58</b>                            |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

200

Section for

County of

Washington County

1414 1/2 Ave.

BARRETT, J. W.

October 22, 1918

1714 1/2 Ave.

W. A. Barrett

Washington County

1714 1/2 Ave.

1714 1/2 Ave.

1/25

Washington County



## 14297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |   |   |   |   |
|--|----------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md.</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>30 yrs.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport</u>                                       |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington County Hospital</u>  |                                  |  |   | d. STREET ADDRESS<br><u>23 Vermont Street</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edward</u> Middle <u>Thomas</u> Last <u>Renner</u>   |                                  |  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>15</u> Year <u>1958</u>  |   |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          | 8. DATE OF BIRTH<br><u>Feb. 22 1885</u> | 9. AGE (In years last birthday)<br><u>73</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>9</u> Days <u>22</u> | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Met &amp; Labor</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Tannery</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Sharpsburg Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>Jacob Renner</u>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Alice Bowers</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>215 01 9918</u>  |   | 17. INFORMANT<br><u>Mr. Willis Renner Williamsport Md</u> Address <u>RED 1</u>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull (Closed); Multiple fracture ribs(closed); Fracture fibula &amp; Tibia (closed); Hemorrhage and shock</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u><br>DUE TO (c) <u></u>   |                                  |  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>None</u>   |                                  |  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Pedestrian who was struck by automobile while crossing street</u> |   |   |   |   |   |
| 20c. TIME OF INJURY<br>Hour <u>6:15</u> p. m. <u>XX</u><br>Month, Day, Year <u>Dec. 15 1958</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Street</u>   |   | 20f. (City or town) (County) (State)<br><u>Williamsport, Wash Md</u>                              |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |  |   |   |   |   |   |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>  |                                  |  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |   |
| EXAMINER'S NAME (Type)<br><u>S. Robert Wells, M.D.</u>   |                                  |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
|  |                                  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Dec. 18-58</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Greenlawn Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Md.</u>                          |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert L. Leaf Williamsport, Md</u>   |                                  |  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 19 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY



14298 CERTIFICATE OF DEATH

Reg. Dist. No.

14309

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, #2</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>   |                                   | e. STREET ADDRESS <u>Nursery Road</u>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Howard</u> Last <u>Ricketts</u>  |                                   | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1958</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 29, 1898</u>                                  |
| 9. AGE (In years last birthday) <u>60</u> yrs.  |                                   | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Charles Edward Ricketts</u>  |                                   | 14. MOTHER'S MAIDEN NAME <u>Josephine Lewis</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>   |                                   | 16. SOCIAL SECURITY NO. <u>217-09-9821A</u>  |  |
| 17. INFORMANT Address <u>Mrs Rosalie Cline 719 Va. Ave.</u>   |                                   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Myocarditis &amp; Cardiac Failure</u><br>DUE TO <u>Chronic Asthma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Asthma</u><br>DUE TO (c) <u>Chronic Asthma</u> |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u><br><u>50 yrs.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>   |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>   |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Dec. 16, 1958</u> to <u>Dec. 16, 1958</u> , that I last saw the deceased alive on <u>Dec. 16, 1958</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.  |                                   |  |  |
| ACTUAL SIGNATURE <u>J. H. Beachley</u> M.D.   |                                   | ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>Dec 16 1958</u>  |  |
| PHYSICIAN'S NAME (Type) <u>J. H. Beachley</u>   |                                   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>12/19/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Church Of God Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Broadfording, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>  |                                   | 24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

|   |  |
|---|--|
| <p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. RACE</p> <p>9. COLOR</p> <p>10. RELIGION</p> <p>11. EDUCATION</p> <p>12. SERVICE</p> <p>13. SOCIAL SECURITY NUMBER</p> <p>14. MOTHER'S MAIDEN NAME</p> <p>15. FATHER'S NAME</p> <p>16. DATE OF DEATH</p> <p>17. PLACE OF DEATH</p> <p>18. CAUSE OF DEATH</p> <p>19. MANNER OF DEATH</p> <p>20. SIGNATURE OF DECEASED</p> <p>21. SIGNATURE OF WITNESSES</p> <p>22. SIGNATURE OF PHYSICIAN</p> <p>23. SIGNATURE OF CORONER</p> <p>24. SIGNATURE OF JUDGE</p> <p>25. SIGNATURE OF CLERK</p> <p>26. SIGNATURE OF REGISTRAR</p> <p>27. SIGNATURE OF CHIEF OF BUREAU</p> <p>28. SIGNATURE OF COMMISSIONER</p> <p>29. SIGNATURE OF SECRETARY</p> <p>30. SIGNATURE OF ASSISTANT SECRETARY</p> <p>31. SIGNATURE OF DEPUTY ASSISTANT SECRETARY</p> <p>32. SIGNATURE OF CHIEF OF DIVISION</p> <p>33. SIGNATURE OF DIVISION CHIEF</p> <p>34. SIGNATURE OF DIVISION CHIEF</p> <p>35. SIGNATURE OF DIVISION CHIEF</p> <p>36. SIGNATURE OF DIVISION CHIEF</p> <p>37. SIGNATURE OF DIVISION CHIEF</p> <p>38. SIGNATURE OF DIVISION CHIEF</p> <p>39. SIGNATURE OF DIVISION CHIEF</p> <p>40. SIGNATURE OF DIVISION CHIEF</p> <p>41. SIGNATURE OF DIVISION CHIEF</p> <p>42. SIGNATURE OF DIVISION CHIEF</p> <p>43. SIGNATURE OF DIVISION CHIEF</p> <p>44. SIGNATURE OF DIVISION CHIEF</p> <p>45. SIGNATURE OF DIVISION CHIEF</p> <p>46. SIGNATURE OF DIVISION CHIEF</p> <p>47. SIGNATURE OF DIVISION CHIEF</p> <p>48. SIGNATURE OF DIVISION CHIEF</p> <p>49. SIGNATURE OF DIVISION CHIEF</p> <p>50. SIGNATURE OF DIVISION CHIEF</p> <p>51. SIGNATURE OF DIVISION CHIEF</p> <p>52. SIGNATURE OF DIVISION CHIEF</p> <p>53. SIGNATURE OF DIVISION CHIEF</p> <p>54. SIGNATURE OF DIVISION CHIEF</p> <p>55. SIGNATURE OF DIVISION CHIEF</p> <p>56. SIGNATURE OF DIVISION CHIEF</p> <p>57. SIGNATURE OF DIVISION CHIEF</p> <p>58. SIGNATURE OF DIVISION CHIEF</p> <p>59. SIGNATURE OF DIVISION CHIEF</p> <p>60. SIGNATURE OF DIVISION CHIEF</p> <p>61. SIGNATURE OF DIVISION CHIEF</p> <p>62. SIGNATURE OF DIVISION CHIEF</p> <p>63. SIGNATURE OF DIVISION CHIEF</p> <p>64. SIGNATURE OF DIVISION CHIEF</p> <p>65. SIGNATURE OF DIVISION CHIEF</p> <p>66. SIGNATURE OF DIVISION CHIEF</p> <p>67. SIGNATURE OF DIVISION CHIEF</p> <p>68. SIGNATURE OF DIVISION CHIEF</p> <p>69. SIGNATURE OF DIVISION CHIEF</p> <p>70. SIGNATURE OF DIVISION CHIEF</p> <p>71. SIGNATURE OF DIVISION CHIEF</p> <p>72. SIGNATURE OF DIVISION CHIEF</p> <p>73. SIGNATURE OF DIVISION CHIEF</p> <p>74. SIGNATURE OF DIVISION CHIEF</p> <p>75. SIGNATURE OF DIVISION CHIEF</p> <p>76. SIGNATURE OF DIVISION CHIEF</p> <p>77. SIGNATURE OF DIVISION CHIEF</p> <p>78. SIGNATURE OF DIVISION CHIEF</p> <p>79. SIGNATURE OF DIVISION CHIEF</p> <p>80. SIGNATURE OF DIVISION CHIEF</p> <p>81. SIGNATURE OF DIVISION CHIEF</p> <p>82. SIGNATURE OF DIVISION CHIEF</p> <p>83. SIGNATURE OF DIVISION CHIEF</p> <p>84. SIGNATURE OF DIVISION CHIEF</p> <p>85. SIGNATURE OF DIVISION CHIEF</p> <p>86. SIGNATURE OF DIVISION CHIEF</p> <p>87. SIGNATURE OF DIVISION CHIEF</p> <p>88. SIGNATURE OF DIVISION CHIEF</p> <p>89. SIGNATURE OF DIVISION CHIEF</p> <p>90. SIGNATURE OF DIVISION CHIEF</p> <p>91. SIGNATURE OF DIVISION CHIEF</p> <p>92. SIGNATURE OF DIVISION CHIEF</p> <p>93. SIGNATURE OF DIVISION CHIEF</p> <p>94. SIGNATURE OF DIVISION CHIEF</p> <p>95. SIGNATURE OF DIVISION CHIEF</p> <p>96. SIGNATURE OF DIVISION CHIEF</p> <p>97. SIGNATURE OF DIVISION CHIEF</p> <p>98. SIGNATURE OF DIVISION CHIEF</p> <p>99. SIGNATURE OF DIVISION CHIEF</p> <p>100. SIGNATURE OF DIVISION CHIEF</p> |  |
|---|--|



14299

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |                                  |  |  |   |   |   |  |
|--|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |                                  |  |  | c. LENGTH OF STAY IN 1b<br><b>12 Hrs</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Wash. county Hospital</b>   |                                  |  |  | e. STREET ADDRESS<br><b>745 Spruce St</b>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PORA</b> Middle <b>ALLISON</b> Last <b>RIDGLEY-POPE</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>8</b> Year <b>1958</b>  |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 28 1872</b> | 9. AGE (In years last birthday)<br><b>86</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>            |  |
| 13. FATHER'S NAME<br><b>Augustus Allison</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Tarner</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>W. Edgar Ridgley 219 Bryan Place</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 congestive heart failure &amp; pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b><br>DUE TO (c)                           |                                  |  |  | Hagerstown Md.<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>yes</b>  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                  |  |
| 21. I certify that I attended the deceased from <b>12/2/58</b> , 19 <b>58</b> , to <b>12/8/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12/8/58</b> , 19 <b>58</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>136 North Potomac St.</b> DATE SIGNED <b>12/9/58</b> |                                  |  |  |   |   |   |  |
| ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D.   |                                  |  |  | Hagerstown, Maryland  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12/11/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery Hagerstown Wash. Co Md</b>  |   | 22d. LOCATION (City, town, or county) (State)         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffran Hagerstown Md.</b>  |                                  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 12 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kneass</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1923

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

|                                   |  |                                   |  |                                 |  |                                  |  |                                     |  |
|-----------------------------------|--|-----------------------------------|--|---------------------------------|--|----------------------------------|--|-------------------------------------|--|
| <p>1. NAME OF DECEASED</p>        |  | <p>2. SEX</p>                     |  | <p>3. AGE</p>                   |  | <p>4. DATE OF BIRTH</p>          |  | <p>5. PLACE OF BIRTH</p>            |  |
| <p>6. OCCUPATION</p>              |  | <p>7. CAUSE OF DEATH</p>          |  | <p>8. MANNER OF DEATH</p>       |  | <p>9. PLACE OF DEATH</p>         |  | <p>10. DATE OF DEATH</p>            |  |
| <p>11. SIGNATURE OF PHYSICIAN</p> |  | <p>12. SIGNATURE OF REGISTRAR</p> |  | <p>13. SIGNATURE OF WITNESS</p> |  | <p>14. SIGNATURE OF DECEASED</p> |  | <p>15. SIGNATURE OF NEXT OF KIN</p> |  |
| <p>16. SIGNATURE OF CLERK</p>     |  | <p>17. SIGNATURE OF JUDGE</p>     |  | <p>18. SIGNATURE OF SHERIFF</p> |  | <p>19. SIGNATURE OF CORONER</p>  |  | <p>20. SIGNATURE OF JURY</p>        |  |

40 YEARS TO BE KEPT IN THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reported to Medical Examiner, S.R. Wells, M.D., Hagerstown, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14300

## CERTIFICATE OF DEATH

14311

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> <u>MARYLAND</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>                            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>28 years</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>254 S. Potomac St.,</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Walter</u> Middle <u>W</u> Last <u>Ritter</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>1</u> Year <u>58</u>  |  |   |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH<br><u>March 26, 1874</u>                                     |  |
| 9. AGE (In years last birthday) <u>84</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>gardener</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Henry Bester</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Winchester, Va.</u>           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><u>William Ritter</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Carper</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>220-10-3122A</u>   |  | 17. INFORMANT<br><u>B. Page Ritter</u> Address <u>Hagerstown, Md.</u>         |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis, cerebral and generalized</u><br>DUE TO <u>334X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years (certain)</u> |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
|  |  |   |  | 20f. (City or town)  |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>58</u> , to <u>Dec. 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>approx. June</u> , 19 <u>58</u> , and that death occurred at <u>5:00A</u> M, from the causes and on the date stated above.<br>EST ADDRESS (Street, city or town, state) DATE SIGNED  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>William T. Layman M.D.</u>   |  |   |  | M.D. <u>100 Professional Arts Bldg.</u> 12/2/58  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>   |  |   |  | <u>Hagerstown</u> <u>Maryland</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   |  | 22b. DATE THEREOF<br><u>12-4-58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Hebron</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Winchester</u> <u>Va.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Kraiss</u> <u>Hagerstown, Md.</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 4 '58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                          |  |







## 14301 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Md.</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>26 yrs</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Claire Street, Extended</b>   |  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Maryland</b>   |  |  |  |
| f. STREET ADDRESS<br><b>Claire Street Extended</b>   |  |  |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Georgia Anna Robinson</b>   |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>12 14 1958</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept 29 1899</b>                                      |  |
| 9. AGE (In years lost birthday)<br><b>59 yrs.</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Bowling Green Ky.</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |  |  | 13. FATHER'S NAME<br><b>John West</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Minervia Grider</b>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>none</b>                                 |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |  |  | 17. INFORMANT<br><b>Erskin M. Robinson Box 379<br/>C/O Koppers Co.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) <b>Hypertension</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>6 hrs.</b><br><b>8 hrs.</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) (County) (State)   |  |  |  | 20g. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>July 10</b> , 19 <b>58</b> , to <b>Sept 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 17</b> , 19 <b>58</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Philip J. Hirshman</b>   |  |  |  | DATE SIGNED <b>12/15/58</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>  |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12-17-1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John R Watson Jr</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br><b>DEC 18 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 14302 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>Life</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown 03</b><br>d. STREET ADDRESS<br><b>1104 Oak Hill Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>Jacob Edward Rudy</b><br>First Middle Last   |                                  | 4. DATE OF DEATH <b>December 21 19 58</b><br>Month Day Year  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>July 16 - 1914</b><br>9. AGE (In years last birthday)<br><b>44</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Owner Printing Shop Printing</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hagerstown, Maryland</b>   |  |
| 11. BIRTHPLACE (State or foreign country)   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>C. Earl Rudy</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lillian Sayles</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b><br>If yes, give war or dates of service <b>--</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-09-7226</b>  |  |
| 17. INFORMANT<br><b>Mrs. Helen Rudy</b>   |                                  | Address<br><b>Hagerstown, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b><br><b>443X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive cardiovascular disease</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 hrs.</b><br><b>1 yr. 10 mo.</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Dec. 21 1958</b> , to <b>Dec. 21 1958</b> , that I last saw the deceased alive on <b>Dec. 21 1958</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE<br><i>W. T. Layman, M.D.</i>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>100 Professional Arts Bldg. 12/23/58</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. W. T. Layman, Public Square Hagerstown, Maryland</b>  |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>12-24-1958</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>  |                                  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH 14382

Westminster

Westminster

Westminster

Westminster

White

Westminster

1100 Oak Hill Avenue

Westminster County Hospital

December 1

Joseph Edward Rudy

Male

White

Male

Westminster, Maryland

General Electric Shop Printing

William Gayles

Carl Rudy

214-0-1234567, Helen Rudy, Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

Westminster, Maryland

12-1-1958

Joseph A. Hinton & Son, Baltimore, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G237 1-5-59 et

14314

14303

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Near Marlowe</u> 85X-3  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>2208 Virginia Ave. "Private Res."</u>   |  | d. STREET ADDRESS<br><u>Falling Waters RFD</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lucy</u> Middle <u>Estella</u> Last <u>Samsell</u>   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>27</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 8 1869</u> 89 yrs.                               |
| 9. AGE (In years last birthday)<br><u>88</u> yrs.  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>8</u> Days <u>18</u> Hours <u></u> Min. <u></u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Near Marlowe W. Va.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   |   |
| 13. FATHER'S NAME<br><u>John G. Samsell</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Prudence Baker</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   |
| 17. INFORMANT<br><u>Mr. J. Wesley Samsell</u>  |  | Address <u>Falling Waters RFD</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stroke</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u><br>DUE TO<br>(c) <u></u>                   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   |  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>               |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>1 Aug.</u> 19 <u>58</u> to <u>27 Dec.</u> 19 <u>58</u> , that I last saw the deceased alive on <u>20 Dec.</u> 19 <u>58</u> , and that death occurred at <u>2:00 p.</u> M, from the causes and on the date stated above. |  |  |   |
| ACTUAL SIGNATURE <u>M. Byrd</u>  |  | ADDRESS (Street, city or town, state) DATE SIGNED <u>28 December, 1958</u>   |   |
| PHYSICIAN'S NAME (Type)  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Dec. 29-58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Riverview Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert Leaf Williamsport, Md</u>  |  | ADDRESS  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 30 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Howard</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

REG. NO. 100

WILLIAM HENRY MIDDLETON  
AUGUST 10 1918

|                        |  |                         |  |
|------------------------|--|-------------------------|--|
| NAME OF DECEASED       |  | WILLIAM HENRY MIDDLETON |  |
| AGE                    |  | 38                      |  |
| SEX                    |  | MALE                    |  |
| RACE                   |  | WHITE                   |  |
| DATE OF DEATH          |  | AUGUST 10 1918          |  |
| PLACE OF DEATH         |  | WASHINGTON, D. C.       |  |
| CAUSE OF DEATH         |  | PNEUMONIA               |  |
| DISEASE                |  | PNEUMONIA               |  |
| SYMPTOMS               |  | FEBRUARY 1918           |  |
| TREATMENT              |  | HOSPITAL                |  |
| PREVIOUS ILLNESS       |  | NONE                    |  |
| MANNER OF DEATH        |  | NATURAL                 |  |
| SIGNATURE OF PHYSICIAN |  | J. H. MIDDLETON         |  |
| SIGNATURE OF WITNESSES |  | J. H. MIDDLETON         |  |
| SIGNATURE OF DECEASED  |  | WILLIAM HENRY MIDDLETON |  |
| SIGNATURE OF REGISTRAR |  | J. H. MIDDLETON         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14304 CERTIFICATE OF DEATH

14315

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  | c. LENGTH OF STAY IN lb<br><u>33 days</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>Wash. Co. Hospital</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport Route 2</u>   |  |
|  |                                  | d. STREET ADDRESS<br><u>Tanmany Manor</u>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Helen</u> Middle <u>A</u> Last <u>Schafer</u>  |                                  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>21</u> Year <u>19 58</u>   |  |
| 5. SEX<br><u>female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-4-1891</u>        |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Hagerstown, Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>James Oliver Butts</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Ella K. Smith</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>220-28-8262</u>   |  |
| 17. INFORMANT<br><u>Edward Schafer</u>   |                                  | Address<br><u>Williamsport, Md. R2</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br><u>442X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9440</u><br>(b) <u>Hypertensive cardiovascular renal disease</u><br>DUE TO<br>(c) <u>12 years</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>18 days</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Intertrochanteric fracture</u>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>Patient fell down at her home</u>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>22 Nov. 19 58</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>  |                                  | 20f. (City or town) (County) (State)<br><u>Hagerstown Wash. Maryland</u>  |  |
| 21. I certify that I attended the deceased from <u>November 19 1958</u> , to <u>December 21 1958</u> , that I last saw the deceased alive on <u>December 20 1958</u> , and that death occurred at <u>1:35A</u> M, from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><u>William T. Layman</u>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>100 Professional Arts Bldg. 12/22/58</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>William T. Layman</u>  |                                  | <u>Hagerstown Maryland</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   |                                  | 22b. DATE THEREOF<br><u>12-24-58</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Kraiss</u>  |                                  | ADDRESS<br><u>Hagerstown, Md.</u>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 24 '58</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |



CERTIFICATE OF DEATH

File No.

State of Maryland

County of Baltimore

City of Baltimore

Decedent's Name

Age

Sex

Marital Status

Occupation

Place of Birth

Date of Birth

Place of Death

Date of Death

Time of Death

Cause of Death

Manner of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Decedent

Signature of Next of Kin

Signature of Minister

Signature of Chaplain

Signature of Pastor

Signature of Rector

Signature of Vicar

Signature of Curate

Signature of Priest

Signature of Father

Signature of Brother

Signature of Sister

Signature of Friend



## 14305 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>321 Brookline Ave</b>   |   | d. STREET ADDRESS<br><b>1321 Brookline Ave</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDWARD</b> Middle <b>ELIJAH</b> Last <b>SHAMBAUGH</b>  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>19</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan'y 7 1911</b>   |
| 9. AGE (In years last birthday)<br><b>47</b> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Meat Cutter</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery store</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph E. Shambaugh</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Autumn N. Dyohe</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |   | 16. SOCIAL SECURITY NO.<br><b>W.W.#3 191-10-7546</b>   |   |
| 17. INFORMANT<br><b>James L. Resh</b>  |   | Address<br><b>321 Brookline Ave</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction due to</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b><br>DUE TO (c) <b>Tumor</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cirrhosis of Liver &amp; ventral hernia &amp; obesity</b>  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Apr 23, 1958</b> , to <b>Dec 19, 1958</b> , that I last saw the deceased alive on <b>May 19, 1958</b> , and that death occurred at <b>9:35</b> M, from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE<br><b>Edward W. Ditto</b>   |   | ADDRESS (Street, city or town, state)<br><b>217 W. Washington St.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. E. W. Ditto</b>  |   | DATE SIGNED<br><b>12-20-58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 22b. DATE THEREOF<br><b>12/21/58</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>   |   | ADDRESS<br><b>Hagerstown Md.</b>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE<br><b>DEC 23 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. House</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 14306 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> COUNTY <b>Washington</b>                  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>15 Yrs</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>413 Summit Ave</b>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>  |  |   |  |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>REPP</b> Last <b>SHILLING</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>24</b> Year <b>19 58</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan'y 2 1889</b>   |  |
| 9. AGE (In years last birthday)<br><b>69</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Construction Worker</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Wash. Co Md.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>James Shilling</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary C. Albert</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>214-10-4601</b>   |  | 17. INFORMANT<br><b>Iona E Shilling 413 Summit Ave</b>                          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma.</b><br><b>162.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>About 6 months</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>Aug. 26, 19 58</b> to <b>Dec. 24, 19 58</b> , that I last saw the deceased alive on <b>Dec. 23, 19 58</b> , and that death occurred at <b>1:15 P.</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ADDRESS (Street, city or town, state)<br><b>119 North Potomac St.</b>   |  |   |  | DATE SIGNED<br><b>12-26-58</b>  |  |   |  |
| ACTUAL SIGNATURE<br><b>R.A. Bell</b>  |  |   |  | M.D. <b>Hagerstown, Maryland.</b>   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>R.A. Bell, M.D.</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>12/27/58</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>  |  |   |  | ADDRESS<br><b>Hagerstown Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 30 '58</b>                               |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>  |  |   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1930

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1931

|   |  |  |  |
|---|--|--|--|
| <p>1. NAME OF DECEASED<br/>JAMES A. SMITH</p>       |  | <p>2. SEX<br/>Male</p>   |  |
| <p>3. AGE<br/>45</p>                                |  | <p>4. DATE OF BIRTH<br/>Jan 15, 1885</p>                           |  |
| <p>5. PLACE OF BIRTH<br/>Baltimore, Md.</p>         |  | <p>6. OCCUPATION<br/>Clerk</p>                                     |  |
| <p>7. MARITAL STATUS<br/>Married</p>                |  | <p>8. DATE OF MARRIAGE<br/>Jan 1, 1910</p>                         |  |
| <p>9. NAME OF SPOUSE<br/>Mary A. Smith</p>          |  | <p>10. PLACE OF MARRIAGE<br/>Baltimore, Md.</p>                    |  |
| <p>11. CAUSE OF DEATH<br/>Heart Disease</p>         |  | <p>12. DATE OF DEATH<br/>Feb 1, 1931</p>                           |  |
| <p>13. PLACE OF DEATH<br/>Home</p>                  |  | <p>14. SIGNATURE OF PHYSICIAN<br/>J. H. Jones</p>                  |  |
| <p>15. SIGNATURE OF DECEASED<br/>James A. Smith</p> |  | <p>16. SIGNATURE OF WITNESSES<br/>John D. Smith, Mary A. Smith</p> |  |
| <p>17. SIGNATURE OF REGISTRAR<br/>John D. Smith</p> |  | <p>18. SIGNATURE OF CLERK<br/>Mary A. Smith</p>                    |  |



14342

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hancock</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>Life</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Hancock</b> |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Died inroute to Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>115 E Main St.</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Robert Francis Shives JR.</b>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>12. 14. 1958</b>   |  |  |   |
| 5. SEX<br><b>M</b>  |  | 6. COLOR OR RACE<br><b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 14. 1912</b>   |   |
| 9. AGE (In years last birthday) yrs.<br><b>46</b>   |  | IF UNDER 1 YEAR<br>Months Days<br><b>1 26</b>  |  | IF UNDER 24 HRS.<br>Hours Min.<br><b>19 58</b>  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery Buisness</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Robert F Shives Sr.</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Vantz</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>217-12-1250</b>  |  | 17. INFORMANT<br>Address <b>Md.</b><br><b>Julia J Shives 115 E. Main St. Hancock</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Myocardial Infarct</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>thick</b><br>DUE TO (c) |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Dec 14, 1958</b> to <b>Dec 14, 1958</b> that I last saw the deceased alive on <b>Dec 14, 1958</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.  |  |  |  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>L.M. Shaffer</b>   |  | M.D.<br><b>Hancock Md</b>  |  | DATE SIGNED<br><b>12/15/58</b>  |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>L.M. Shaffer Hancock Maryland.</b>  |  |  |  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>12.17.58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Peters Catholic</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hancock Washington Md.</b>                 |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard F. Stone Hancock Md</b>   |  |  |  | ADDRESS<br><b>Hancock Md</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 19 58</b>   |   |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |   |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                          |  |                    |  |                        |  |                    |  |                      |  |                       |  |
|--------------------------|--|--------------------|--|------------------------|--|--------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED         |  | AGE                |  | SEX                    |  | RACE               |  | DATE OF DEATH        |  | PLACE OF DEATH        |  |
| Robert E. Johnson        |  | 45                 |  | Male                   |  | White              |  | 1945                 |  | Baltimore, Md.        |  |
| RESIDENCE                |  | OCCUPATION         |  | CAUSE OF DEATH         |  | MANNER OF DEATH    |  | DATE OF BIRTH        |  | PLACE OF BIRTH        |  |
| 1234 Main St.            |  | Teacher            |  | Heart Disease          |  | Natural            |  | 1900                 |  | Baltimore, Md.        |  |
| FATHER                   |  | MOTHER             |  | SPOUSE                 |  | CHILDREN           |  | EDUCATION            |  | RELIGION              |  |
| John E. Johnson          |  | Mary E. Johnson    |  | Elizabeth Johnson      |  | Robert Johnson     |  | High School          |  | Roman Catholic        |  |
| DATE OF INTERMENT        |  | PLACE OF INTERMENT |  | NAME OF MINISTER       |  | NAME OF CHURCH     |  | NAME OF FUNERAL HOME |  | NAME OF CEMETERY      |  |
| 1945                     |  | St. Mary's Church  |  | Father E. Johnson      |  | St. Mary's Church  |  | Johnson & Sons       |  | St. Mary's Cemetery   |  |
| DATE OF REPORT           |  | REPORTED BY        |  | SIGNATURE OF REPORTER  |  | TITLE OF REPORTER  |  | DATE OF EXAMINATION  |  | SIGNATURE OF EXAMINER |  |
| 1945                     |  | John E. Johnson    |  | [Signature]            |  | Physician          |  | 1945                 |  | [Signature]           |  |
| DATE OF CORONER'S REPORT |  | CORONER'S REPORT   |  | CORONER'S SIGNATURE    |  | CORONER'S TITLE    |  | DATE OF AUTOPSY      |  | AUTOPSY REPORT        |  |
| 1945                     |  | [Text]             |  | [Signature]            |  | Coroner            |  | 1945                 |  | [Text]                |  |
| DATE OF VERIFICATION     |  | VERIFICATION       |  | VERIFICATION SIGNATURE |  | VERIFICATION TITLE |  | DATE OF REGISTRATION |  | REGISTRATION          |  |
| 1945                     |  | [Text]             |  | [Signature]            |  | Registrar          |  | 1945                 |  | [Text]                |  |



14307

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                   | c. LENGTH OF STAY IN 1b<br><b>1 month</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHANN</b> Middle <b>NG</b> Last <b>SHU</b>  |                                   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>7</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Yellow</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 26, 1888</b>     |
| 9. AGE (In years last birthday)<br><b>70 yrs.</b>   |                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laundryman</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Chinese Laundry</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Canton, China</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>China</b>  |   |
| 13. FATHER'S NAME<br><b>unknown</b>   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                   | 16. SOCIAL SECURITY NO.<br><b>218-30-9444A</b>  |   |
| 17. INFORMANT<br><b>Louie F. You</b>  |                                   | Address<br><b>Hagerstown, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Nephrosclerosis</b><br>446X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) |                                   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yr</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Nov 24, 1958</b> to <b>Dec 7, 1958</b> , that I last saw the deceased alive on <b>Dec 7, 1958</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.  |                                   |   |   |
| ACTUAL SIGNATURE <b>Robert V. H. Campbell</b> M.D.  |                                   | ADDRESS (Street, city or town, state) <b>145 W Washington St</b> DATE SIGNED <b>12/8/58</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>  |                                   | <b>Hagerstown Md</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                   | 22b. DATE THEREOF<br><b>12/10/1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>  |                                   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Suter-Rouzer Funeral Home</b><br><b>R. Franklin Rouzer</b>   |                                   | 24a. REC'D BY REGISTRAR<br><b>DEC 10 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                              |  |                                     |  |                                 |  |                                |  |                                   |  |                                   |  |                                 |  |                                   |  |                                 |  |                                   |  |                                   |  |                                 |  |
|------------------------------|--|-------------------------------------|--|---------------------------------|--|--------------------------------|--|-----------------------------------|--|-----------------------------------|--|---------------------------------|--|-----------------------------------|--|---------------------------------|--|-----------------------------------|--|-----------------------------------|--|---------------------------------|--|
| <p>1. Name of deceased</p>   |  | <p>2. Sex</p>                       |  | <p>3. Age</p>                   |  | <p>4. Date of birth</p>        |  | <p>5. Place of birth</p>          |  | <p>6. Date of death</p>           |  | <p>7. Place of death</p>        |  | <p>8. Cause of death</p>          |  | <p>9. Manner of death</p>       |  | <p>10. Signature of physician</p> |  | <p>11. Signature of registrar</p> |  | <p>12. Date of registration</p> |  |
| <p>13. Name of informant</p> |  | <p>14. Relationship to deceased</p> |  | <p>15. Address of informant</p> |  | <p>16. Date of information</p> |  | <p>17. Signature of informant</p> |  | <p>18. Signature of registrar</p> |  | <p>19. Date of registration</p> |  | <p>20. Signature of registrar</p> |  | <p>21. Date of registration</p> |  | <p>22. Signature of registrar</p> |  | <p>23. Date of registration</p>   |  |                                 |  |
| <p>24. Name of informant</p> |  | <p>25. Relationship to deceased</p> |  | <p>26. Address of informant</p> |  | <p>27. Date of information</p> |  | <p>28. Signature of informant</p> |  | <p>29. Signature of registrar</p> |  | <p>30. Date of registration</p> |  | <p>31. Signature of registrar</p> |  | <p>32. Date of registration</p> |  | <p>33. Signature of registrar</p> |  | <p>34. Date of registration</p>   |  |                                 |  |
| <p>35. Name of informant</p> |  | <p>36. Relationship to deceased</p> |  | <p>37. Address of informant</p> |  | <p>38. Date of information</p> |  | <p>39. Signature of informant</p> |  | <p>40. Signature of registrar</p> |  | <p>41. Date of registration</p> |  | <p>42. Signature of registrar</p> |  | <p>43. Date of registration</p> |  | <p>44. Signature of registrar</p> |  | <p>45. Date of registration</p>   |  |                                 |  |



14308 CERTIFICATE OF DEATH

14320

Reg. Dist. No. 302

|  |                                  |   |  |   |   |   |                  |
|--|----------------------------------|---|--|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>7 Yrs</b>   |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>36 No Walnut st</b>   |                                  |   |  | d. STREET ADDRESS<br><b>36 No Walnut st</b>   |   |   |                  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |   |   |   |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>ALFRED</b> Last <b>SMEADLEY</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>30</b> Year <b>1958</b>  |   |   |                  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 19 1887</b> | 9. AGE (In years last birthday)<br><b>71</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Restaurant Operator Retired</b>  |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Front Royal Warren Co</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>                         |                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |   |  |   |   |   |                  |
| 13. FATHER'S NAME<br><b>newton Smeadley</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>No Record</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  |   |  | 16. SOCIAL SECURITY NO.<br><b>780-14-5539</b>   |   | 17. INFORMANT<br><b>Mrs Mary K. Smeadley 36 No Walnut St</b>                    |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Codswalsh &amp; Brown Basin</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)  |                                  |   |  | Hagerstown Md.  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b>                                |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |                  |
|  |                                  |   |  | 20f. (City or town) (County) (State)  |   |   |                  |
| 21. I certify that I attended the deceased from <b>12/29/58</b> to <b>12/30/58</b> , that I last saw the deceased alive on <b>12/30/58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>12/30/58</b><br>ACTUAL SIGNATURE <b>Robert L. Young M.D.</b><br>PHYSICIAN'S NAME (Type) |                                  |   |  |   |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1/2/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md.</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md.</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 5 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Clairmont H. Hume</b>                          |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



*[The page contains faint, illegible vertical text.]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14343

## CERTIFICATE OF DEATH

## 14321

Reg. Dist. No.

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Quantico Va.</b>    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hancock Maryland.</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Quantico Va.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                     | d. STREET ADDRESS   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Ann Smith</b>   |                                     | 4. DATE OF DEATH<br>Month Day Year<br><b>12 4 19 58</b>   |  |
| 5. SEX<br><b>F.</b>  | 6. COLOR OR RACE<br><b>W.</b>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 13. 1916</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>42</b>  |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>East St. Louis Ill.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>George Hlavaty</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Anna Simko</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |  |
| 17. INFORMANT<br><b>Joseph E Smith</b>   |                                     | Address<br><b>Quantico Va.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                     |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |
| 20f. (City or town)  |                                     | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Dec 4, 1958</b> , to <b>Dec 4, 1958</b> , that I last saw the deceased alive on <b>Dec 4, 1958</b> , and that death occurred at <b>3:55 P.M.</b> from the causes and on the date stated above.  |                                     |   |  |
| ACTUAL SIGNATURE <b>Frank B Thomas III MD</b>  |                                     | DATE SIGNED <b>Hancock, Md.</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Frank B Thomas Hancock Md.</b>  |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>12.8.58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Community Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Cudahy Milwaukee Wis.</b>                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard F. George Hancock Md.</b>  |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 8 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                     |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1908

Age 10

Residence 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14322

Reg. Dist. No.

14309

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |   | c. LENGTH OF STAY IN TB<br><u>1 week</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Wash. Co. Hospital</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Annie</u> Middle <u>Belle</u> Last <u>Smith</u>   |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>16</u> Year <u>19 58</u>   |  |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb. 7, 1890</u>                                |
| 9. AGE (In years lost birthday)<br><u>73</u> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min.                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>Frederick, Md.</u>     |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 13. FATHER'S NAME<br><u>Daniel Martin</u>   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Agnes Fuller</u>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                      |  |
| 16. SOCIAL SECURITY NO.<br><u>none</u>  |   | 17. INFORMANT<br><u>Gussie V. Willis</u> Address <u>Hagerstown, Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive-arteriosclerotic Heart Disease</u> DUE TO<br>(c) <u>Uncertain</u><br><u>-5 yrs or more</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <u>9-19, 1944</u> to <u>12/16, 1958</u> , that I last saw the deceased alive on <u>12/16, 1958</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE <u>John H. Hornbaker</u>   |   | ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Md.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>  |   | DATE SIGNED <u>12:18:58</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  | 22b. DATE THEREOF<br><u>12-19-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Kraiss</u> Address <u>Hagerstown, Md.</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 22 '58</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Kraus</u>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

|                  |  |           |  |           |  |           |  |               |  |                |  |           |  |           |  |         |  |
|------------------|--|-----------|--|-----------|--|-----------|--|---------------|--|----------------|--|-----------|--|-----------|--|---------|--|
| NAME OF DECEASED |  | AGE       |  | SEX       |  | RACE      |  | DATE OF BIRTH |  | PLACE OF BIRTH |  | CITY      |  | STATE     |  | COUNTRY |  |
| JAMES M. SMITH   |  | 45        |  | M         |  | W         |  | 1905          |  | BALTIMORE      |  | MD        |  | USA       |  | USA     |  |
| MARRIAGE         |  | DATE      |  | PLACE     |  | CITY      |  | STATE         |  | COUNTRY        |  | CITY      |  | STATE     |  | COUNTRY |  |
| MARRIED          |  | 1925      |  | BALTIMORE |  | MD        |  | USA           |  | BALTIMORE      |  | MD        |  | USA       |  | USA     |  |
| EDUCATION        |  | SCHOOL    |  | CITY      |  | STATE     |  | COUNTRY       |  | CITY           |  | STATE     |  | COUNTRY   |  | CITY    |  |
| HIGH SCHOOL      |  | BALTIMORE |  | MD        |  | USA       |  | BALTIMORE     |  | MD             |  | USA       |  | BALTIMORE |  | MD      |  |
| OCCUPATION       |  | BUSINESS  |  | CITY      |  | STATE     |  | COUNTRY       |  | CITY           |  | STATE     |  | COUNTRY   |  | CITY    |  |
| MANAGER          |  | BALTIMORE |  | MD        |  | USA       |  | BALTIMORE     |  | MD             |  | USA       |  | BALTIMORE |  | MD      |  |
| CAUSE OF DEATH   |  | HEART     |  | CITY      |  | STATE     |  | COUNTRY       |  | CITY           |  | STATE     |  | COUNTRY   |  | CITY    |  |
| CORONARY         |  | BALTIMORE |  | MD        |  | USA       |  | BALTIMORE     |  | MD             |  | USA       |  | BALTIMORE |  | MD      |  |
| MANNER OF DEATH  |  | NATURAL   |  | CITY      |  | STATE     |  | COUNTRY       |  | CITY           |  | STATE     |  | COUNTRY   |  | CITY    |  |
| NATURAL          |  | BALTIMORE |  | MD        |  | USA       |  | BALTIMORE     |  | MD             |  | USA       |  | BALTIMORE |  | MD      |  |
| DATE OF DEATH    |  | 1950      |  | CITY      |  | STATE     |  | COUNTRY       |  | CITY           |  | STATE     |  | COUNTRY   |  | CITY    |  |
| 1950             |  | BALTIMORE |  | MD        |  | USA       |  | BALTIMORE     |  | MD             |  | USA       |  | BALTIMORE |  | MD      |  |
| PLACE OF DEATH   |  | HOME      |  | CITY      |  | STATE     |  | COUNTRY       |  | CITY           |  | STATE     |  | COUNTRY   |  | CITY    |  |
| HOME             |  | BALTIMORE |  | MD        |  | USA       |  | BALTIMORE     |  | MD             |  | USA       |  | BALTIMORE |  | MD      |  |
| CITY             |  | BALTIMORE |  | STATE     |  | MD        |  | COUNTRY       |  | USA            |  | CITY      |  | BALTIMORE |  | STATE   |  |
| BALTIMORE        |  | MD        |  | USA       |  | BALTIMORE |  | MD            |  | USA            |  | BALTIMORE |  | MD        |  | USA     |  |

REGISTERED PROFESSIONAL NURSE

DATE OF REGISTRATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14344

## CERTIFICATE OF DEATH

14323

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural Smithsburg</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>62 years</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>RFD #1</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Maggie</b> Middle <b>May</b> Last <b>Smith</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>7</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 29, 1876</b> |
| 9. AGE (In years last birthday) yrs. <b>81</b>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>house wife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Leitersburg, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Fred Myers</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lydia Miner</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>Mrs. Katherine Milburn, Hagerstown, Md.</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO (c)  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hours</b><br><b>years.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>24 Nov 1958</b> to <b>7 Dec 1958</b> , that I last saw the deceased alive on <b>6 Dec 1958</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</b><br>DATE SIGNED <b>11/8/58</b><br>ACTUAL SIGNATURE <b>J. D. WILSON, M.D.</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>J. D. WILSON, M.D.</b> |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                                  | 22b. DATE THEREOF<br><b>12-10-58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Smithsburg, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>   |                                  | ADDRESS<br><b>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>DEC 10 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles J. Trumble</b>  |  |







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14324

14310

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural, Smithsburg</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Washington County Hospital</u>  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Albert</u> Middle <u>Harbaugh</u> Last <u>Snively</u>  |                                      | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>25</u> Year <u>19 58</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4/15/1910</u>   |
| 9. AGE (In years last birthday)<br><u>48</u> yrs.  |                                      | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Landscaper &amp; Machinist</u>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Waynesboro Pa.</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Wilbur R. Snively</u>  |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Nellie B. Harbaugh</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                                      | 16. SOCIAL SECURITY NO.<br><u>173-03-1086</u>  |  |
| 17. INFORMANT<br><u>Mrs. Albert H. Snively, Smithsburg Md., #2</u>   |                                      | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas with Metastases</u><br><u>157X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> |                                      |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      |  |  |
| MEDICAL CERTIFICATION  |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>19</u> p. m. <u>  </u>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>12/11</u> , 19 <u>58</u> , to <u>12/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/25</u> , 19 <u>58</u> , and that death occurred at <u>6:05 P.M.</u> , from the causes and on the date stated above.   |                                      |  |  |
| ACTUAL SIGNATURE <u>Dalton M. Dally</u> M.D.   |                                      | ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>12/24/58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY</u>   |                                      |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>12/27/58</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Green Hill</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Waynesboro, Franklin Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Walter J. Shaw, Waynesboro Pa.</u>  |                                      | 24a. REC'D BY REGISTRAR<br><u>DEC 29 '58</u>   |  |
| ADDRESS  |                                      | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Kline</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14311

CERTIFICATE OF DEATH

14325

Reg. Dist. No. 303

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                               |  |                                     |   |  |  |  |
|--|-------------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                               |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |                               |  |                                     | c. LENGTH OF STAY IN 1b <u>4 Weeks</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>  |                               |  |                                     | e. STREET ADDRESS <u>Boonshoff / R / Funkstown</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>CLINTON</u> Last <u>SOUTH</u>   |                               |  |                                     | 4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1958</u>  |  |  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 21 1861</u> |   | 9. AGE (In years last birthday) <u>97</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |                                     | 11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                      |  |
| 13. FATHER'S NAME <u>Benj Geary South</u>  |                               |  |                                     | 14. MOTHER'S MAIDEN NAME <u>Margaret Young</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |                                     | 17. INFORMANT Address <u>Frank Welty Hagerstown Md. R # 3</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis with Uremia</u><br><u>610X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Benign Prostatic Hypertrophy</u> DUE TO<br>(c) <u></u>                   |                               |  |                                     |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u><br><u>10 years</u>        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calculus in Urinary Bladder</u>   |                               |  |                                     |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Oct 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>58</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>998 Potomac Rd. Hagerstown</u> DATE SIGNED <u>10-9-58</u> |                               |  |                                     |   |  |  |  |
| ACTUAL SIGNATURE <u>Dalton M. Welty</u> M.D.   |                               |  |                                     | PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>12/10/58</u>  |                                     | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>   |                               |  |                                     | 24a. REC'D BY REGISTRAR DATE <u>DEC 12 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>                            |  |







14312

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>PA</u> b. COUNTY <u>Fulton</u> ✓                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL AMARANTH 75X-3</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hosp.</u>  |                                      | d. STREET ADDRESS _____  |  |
| 3. NAME OF DECEASED (Type or print) <u>Bertha Grace Spade</u>  |                                      | 4. DATE OF DEATH <u>Dec 24 1958</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 15 1892</u>   |
| 9. AGE (In years lost birthday) <u>66 yrs.</u>   |                                      | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. <u>6 9 - -</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>AMARANTH PA</u>   |                                      | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>John S. Engle</u>   |                                      | 14. MOTHER'S MAIDEN NAME <u>Rebecca Smith</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>  |                                      | 16. SOCIAL SECURITY NO. <u>—</u>   |  |
| 17. INFORMANT <u>Walter R Spade</u>  |                                      | Address <u>Amaranth PA</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-vascular arteriosclerosis</u><br>DUE TO (c) <u>Hypertensive cardiovascular disease</u> |                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>years</u><br><u>years</u>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>  |                                      |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Dec 19, 1958</u> to <u>Dec 24, 1958</u> , that I last saw the deceased alive on <u>Dec 24, 1958</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.  |                                      |  |  |
| ACTUAL SIGNATURE <u>R. S. Stauffer</u>   |                                      | ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown, Md.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u>  |                                      | DATE SIGNED _____  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF <u>Dec 28 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Cem.</u>   | 22d. LOCATION (City, town, or county) (State) <u>AMARANTH, FULTON CO, PA.</u>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Sipes</u>  |                                      | ADDRESS <u>Harrisonville PA</u>  |  |
| 24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>  |                                      | 24b. REGISTRAR'S SIGNATURE <u>William Sipes</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1912

FILE NO.

DATE OF DEATH

PLACE

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

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RECEIVED BY THE STATE DEPARTMENT OF HEALTH  
BALTIMORE, MD.  
JAN 1 1912



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14345

## CERTIFICATE OF DEATH

14327

Reg. Dist. No.

|   |                        |  |                               |
|---|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Md. b. COUNTY Washington                               |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville   |                        | c. LENGTH OF STAY IN 1b 10 yrs.  |                               |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mennonite Home   |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |
| 3. NAME OF DECEASED (Type or print) First Bertha Middle Kate Last Spielman  |                        | 4. DATE OF DEATH Month 12 Day 15 Year 19 58  |                               |
| 5. SEX female   | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb 24, 1871 |
| 9. AGE (In years last birthday) 87 yrs.   |                        | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife   |                        | 10b. KIND OF BUSINESS OR INDUSTRY home   |                               |
| 11. BIRTHPLACE (State or foreign country) Hagerstown, Md.   |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                               |
| 13. FATHER'S NAME Amos Spielman   |                        | 14. MOTHER'S MAIDEN NAME Katherine McCoy   |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)  |                        | 16. SOCIAL SECURITY NO. none   |                               |
| 17. INFORMANT Mrs. Carrie Jones   |                        | Address Hagerstown, Md.  |                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Coronary Occlusion<br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Sclerosis<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                        | INTERVAL BETWEEN ONSET AND DEATH 3 hrs.<br>10 yrs.   |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19  |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work   |                               |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                               |
| 21. I certify that I attended the deceased from Dec. 9, 1958, to Dec. 15, 1958, that I last saw the deceased alive on Dec. 14, 1958, and that death occurred at 3 P.M. from the causes and on the date stated above.  |                        |  |                               |
| ACTUAL SIGNATURE David R. Brewer M.D.   |                        | ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 12/16/58  |                               |
| PHYSICIAN'S NAME (Type) David R. Brewer   |                        |  |                               |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial  |                        | 22b. DATE THEREOF 12-17-58   |                               |
| 22c. NAME OF CEMETERY OR CREMATORY St. Peters Lutheran  |                        | 22d. LOCATION (City, town, or county) (State) Clear Spring Md.   |                               |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Clark   |                        | ADDRESS Clear Spring, Md.  |                               |
| 24a. REC'D BY REGISTRAR DATE DEC 19 '58   |                        | 24b. REGISTRAR'S SIGNATURE Arthur S. House   |                               |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14313

## CERTIFICATE OF DEATH

14328

Reg. Dist. No.

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>               |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAGERSTOWN</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>3 Weeks</u>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>WASHINGTON COUNTY Hospital</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CLAUDE</u> Middle <u>F</u> Last <u>STONE</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>30</u> Year <u>19 58</u>  |                                      |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-28-1901</u> |
| 9. AGE (In years last birthday) <u>57</u> yrs.   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Meter Reader, City Light</u>                            |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><u>Brunswick Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                      |
| 13. FATHER'S NAME<br><u>Edward Stone</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Delila Dick</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>214-09-8368</u>  |                                      |
| 17. INFORMANT<br><u>Mrs. Claude F. Stone</u>   |                                  | Address <u>Hagerstown Md. 708 W. Franklin St.,</u>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>L A E N N E C ' S C I R R H O S I S</u><br><u>581.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs.</u>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. n. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <u>McH</u> , 19 <u>53</u> , to <u>Dec 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P</u> M, from the causes and on the date stated above.   |                                  |  |                                      |
| ACTUAL SIGNATURE <u>B B Kneisley</u>   |                                  | ADDRESS (Street, city or town, state) <u>148 W. Washington St.</u>   |                                      |
| PHYSICIAN'S NAME (Type) <u>B. B. KNEISLEY</u>  |                                  | DATE SIGNED <u>12/31/58</u>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>1/2/59</u>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Burns Hill</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Waynesboro, Franklin Pa.</u>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Nathan G. Stone</u>   |                                  | 24a. REC'D BY REGISTRAR<br><u>JAN 6 '59</u>  |                                      |
| ADDRESS<br><u>Waynesboro</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Harris</u>  |                                      |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14346 CERTIFICATE OF DEATH

14329

Reg. Dist. No. 302

|   |                                  |  |  |   |  |  |   |
|---|----------------------------------|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Hagerstown</b>   |                                  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>x Rural Hagerstown</b>                                 |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R.F.D. # 3</b>   |                                  |  |  | d. STREET ADDRESS<br><b>R.F.D. # 3</b>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLA</b> Middle <b>HINSMAN</b> Last <b>STONEBRAKER</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>6</b> Year <b>1958</b>   |  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>April 2, 1885</b> |   | 9. AGE (In years last birthday)<br><b>73</b> yrs.                    | IF UNDER 1 YEAR<br>Months Days Hours Min.                              | IF UNDER 24 HRS.<br>Hours Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY        |   | 11. BIRTHPLACE (State or foreign country)<br><b>New Haven, Conn.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Edward Hinsman</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Wilmot</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mr. John Stinebraker</b> Address <b>Hagerstown Rt. 3, Md.</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Aortic aneurysm</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular Disease</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>2 yrs.</b>    |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |   |
| 21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>57</b> , to <b>Dec 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec - 6</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>214 N. Potomac st. Hagerstown, Md.</b><br>DATE SIGNED <b>12/8/58</b>   |                                  |  |  |   |  |  |   |
| ACTUAL SIGNATURE <b>Lloyd A. Hoffner</b> M.D.   |                                  |  |  | PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffner Hagerstown, Md.</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>12/9/1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Suter-Rouzer Funeral Home</b><br><b>A. Franklin Ringer</b>   |                                  |  |  | ADDRESS<br><b>Hagerstown, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 10 58</b><br>DATE                    |   |
|   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Ringer</b>   |  |  |   |







## 14347 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE _____ b. COUNTY _____                                     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown R # 2</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>10 yrs.</b>   |  |  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Transient Construction Worker</b>   |  |   |  | d. STREET ADDRESS<br>_____  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Gateway Convalescent Home</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>GRANT</b> Last <b>STRIDE</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>17</b> Year <b>19 58</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 27, 1885</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.  |  | IF UNDER 1 YEAR<br>Months _____ Days _____        |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Construction Worker</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>_____  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Sharpsburg Wash. Co. Md.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Samuel Stride</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Swain ?</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>   |  | (If yes, give war or dates of service) <b>WWL</b> |  | 16. SOCIAL SECURITY NO.<br><b>195-07-0430</b>   |  | 17. INFORMANT<br><b>Richard Harbaugh 302 N. Locust St. Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Muscular Dystrophy</b><br>744.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>Jan 14, 1954</b> to <b>Dec 17, 1958</b> that I last saw the deceased alive on <b>Dec 16, 1958</b> and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>12/20/58</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>David R. Brewer</b> M.D.  |  |   |  | <b>Clearspring, Md.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12/20/58</b>              |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 22 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Charles S. ...</i>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Wm. G. Host d-m*







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14331

14314

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |   |                                    |   |   |
|---|---------------------------|---|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Washington MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Md.  |                                    | b. COUNTY<br>Washington   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown  |                           | c. LENGTH OF STAY IN 1b<br>5 days   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>03 Hagerstown |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Wash. Co. Hospital  |                           | d. STREET ADDRESS<br>2010 Virginia Ave.,  |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>John Evers Swope  |                           | 4. DATE OF DEATH<br>Month Day Year<br>12 10 19 58   |                                    |   |   |
| 5. SEX<br>male  | 6. COLOR OR RACE<br>white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>April 20, 1886 | 9. AGE (In years last birthday)<br>72 yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>conductor  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Railroad   |                                    | 11. BIRTHPLACE (State or foreign country)<br>Md.  |   |
| 13. FATHER'S NAME<br>George William Swope   |                           | 14. MOTHER'S MAIDEN NAME<br>unknown   |                                    |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no   |                           | 16. SOCIAL SECURITY NO.<br>705-10-5011  |                                    | 17. INFORMANT<br>Mrs. Mary Swope Hagerstown, Md.  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 446X DUE TO Thrombosis - Pulmonary artery<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease<br>(c) Nephrosclerosis |                           | INTERVAL BETWEEN ONSET AND DEATH<br>1 week  |                                    |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |   |
| 20f. (City or town)<br>Hagerstown   |                           | 20g. (County)<br>Washington   |                                    | 20h. (State)<br>Md.   |   |
| 21. I certify that I attended the deceased from Dec. 3, 1958, to Dec. 11, 1958, that I last saw the deceased alive on Dec. 10, 1958, and that death occurred at 2:00 P.M. from the causes and on the date stated above.   |                           |   |                                    |   |   |
| ACTUAL SIGNATURE<br>Physician   |                           | ADDRESS (Street, city or town, state)<br>1596 Washington St Hagerstown Md   |                                    | DATE SIGNED<br>12/11/58   |   |
| PHYSICIAN'S NAME (Type)   |                           |   |                                    |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial   |                           | 22b. DATE THEREOF<br>12-13-58   |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br>Rose Hill   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Fred W. Kr aiss   |                           | ADDRESS<br>Hagerstown, Md.  |                                    | 24a. REC'D BY REGISTRAR<br>DATE DEC 15 '58  |   |
|   |                           |   |                                    | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Howard  |   |







## 14315 CERTIFICATE OF DEATH

14332

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>D.O.A. Washington County Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>1098 Marshall St.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROY</b> Middle <b>EDMOND</b> Last <b>TALL</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>8</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 28, 1884</b>  |  |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Refrig. Industry</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington Co. Md.</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>John Tall</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Steffey</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>217-12-2246</b>   |  | 17. INFORMANT<br><b>Mrs. Roy Tall</b> Address <b>1098 Marshall St. Hagerstown, Md.</b>            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>260X</b> DUE TO <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b><br>(c) <b>Diabetes mellitus</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b><br><b>years</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month <b>19</b> Day <b>19</b> Year <b>1958</b><br>Hour a. m. p. m.  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)<br><b>Hagerstown</b>   |  |   |  | 20g. (County)<br><b>Md.</b>   |  | 20h. (State)<br><b>Md.</b>  |  |
| 21. I certify that I attended the deceased from <b>4-12</b> , 19 <b>58</b> , to <b>11-24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/24</b> , 19 <b>58</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>135 N. Potomac St. Hagerstown, Maryland.</b><br>DATE SIGNED <b>12/9/58</b><br>ACTUAL SIGNATURE <b>D. J. Boyer</b><br>PHYSICIAN'S NAME (Type) <b>D. J. Boyer, M.D.</b>                  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12/11/58</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 11 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS            |  | 2. SEX<br>Male                            |  |
| 3. AGE<br>65                                      |  | 4. RACE<br>White                          |  |
| 5. DATE OF DEATH<br>October 15, 1944              |  | 6. PLACE OF DEATH<br>Home                 |  |
| 7. TIME OF DEATH<br>10:30 AM                      |  | 8. CAUSE OF DEATH<br>Heart Disease        |  |
| 9. DISEASE OR INJURY<br>Coronary Artery Disease   |  | 10. PLACE OF BIRTH<br>Maryland            |  |
| 11. DATE OF BIRTH<br>March 15, 1879               |  | 12. PLACE OF BIRTH<br>Baltimore, Maryland |  |
| 13. NAME OF PHYSICIAN<br>Dr. J. H. Harris         |  | 14. NAME OF FUNERAL HOME<br>None          |  |
| 15. NAME OF NEXT OF KIN<br>Mrs. J. H. Harris      |  | 16. NAME OF WITNESS<br>None               |  |
| 17. SIGNATURE OF PHYSICIAN<br>J. H. Harris        |  | 18. SIGNATURE OF FUNERAL HOME<br>None     |  |
| 19. SIGNATURE OF NEXT OF KIN<br>Mrs. J. H. Harris |  | 20. SIGNATURE OF WITNESS<br>None          |  |
| 21. NAME OF REGISTRAR<br>None                     |  | 22. NAME OF CLERK<br>None                 |  |
| 23. NAME OF DEPUTY CLERK<br>None                  |  | 24. NAME OF ASSISTANT CLERK<br>None       |  |
| 25. NAME OF CLERK<br>None                         |  | 26. NAME OF ASSISTANT CLERK<br>None       |  |
| 27. NAME OF CLERK<br>None                         |  | 28. NAME OF ASSISTANT CLERK<br>None       |  |
| 29. NAME OF CLERK<br>None                         |  | 30. NAME OF ASSISTANT CLERK<br>None       |  |
| 31. NAME OF CLERK<br>None                         |  | 32. NAME OF ASSISTANT CLERK<br>None       |  |
| 33. NAME OF CLERK<br>None                         |  | 34. NAME OF ASSISTANT CLERK<br>None       |  |
| 35. NAME OF CLERK<br>None                         |  | 36. NAME OF ASSISTANT CLERK<br>None       |  |
| 37. NAME OF CLERK<br>None                         |  | 38. NAME OF ASSISTANT CLERK<br>None       |  |
| 39. NAME OF CLERK<br>None                         |  | 40. NAME OF ASSISTANT CLERK<br>None       |  |
| 41. NAME OF CLERK<br>None                         |  | 42. NAME OF ASSISTANT CLERK<br>None       |  |
| 43. NAME OF CLERK<br>None                         |  | 44. NAME OF ASSISTANT CLERK<br>None       |  |
| 45. NAME OF CLERK<br>None                         |  | 46. NAME OF ASSISTANT CLERK<br>None       |  |
| 47. NAME OF CLERK<br>None                         |  | 48. NAME OF ASSISTANT CLERK<br>None       |  |
| 49. NAME OF CLERK<br>None                         |  | 50. NAME OF ASSISTANT CLERK<br>None       |  |
| 51. NAME OF CLERK<br>None                         |  | 52. NAME OF ASSISTANT CLERK<br>None       |  |
| 53. NAME OF CLERK<br>None                         |  | 54. NAME OF ASSISTANT CLERK<br>None       |  |
| 55. NAME OF CLERK<br>None                         |  | 56. NAME OF ASSISTANT CLERK<br>None       |  |
| 57. NAME OF CLERK<br>None                         |  | 58. NAME OF ASSISTANT CLERK<br>None       |  |
| 59. NAME OF CLERK<br>None                         |  | 60. NAME OF ASSISTANT CLERK<br>None       |  |
| 61. NAME OF CLERK<br>None                         |  | 62. NAME OF ASSISTANT CLERK<br>None       |  |
| 63. NAME OF CLERK<br>None                         |  | 64. NAME OF ASSISTANT CLERK<br>None       |  |
| 65. NAME OF CLERK<br>None                         |  | 66. NAME OF ASSISTANT CLERK<br>None       |  |
| 67. NAME OF CLERK<br>None                         |  | 68. NAME OF ASSISTANT CLERK<br>None       |  |
| 69. NAME OF CLERK<br>None                         |  | 70. NAME OF ASSISTANT CLERK<br>None       |  |
| 71. NAME OF CLERK<br>None                         |  | 72. NAME OF ASSISTANT CLERK<br>None       |  |
| 73. NAME OF CLERK<br>None                         |  | 74. NAME OF ASSISTANT CLERK<br>None       |  |
| 75. NAME OF CLERK<br>None                         |  | 76. NAME OF ASSISTANT CLERK<br>None       |  |
| 77. NAME OF CLERK<br>None                         |  | 78. NAME OF ASSISTANT CLERK<br>None       |  |
| 79. NAME OF CLERK<br>None                         |  | 80. NAME OF ASSISTANT CLERK<br>None       |  |
| 81. NAME OF CLERK<br>None                         |  | 82. NAME OF ASSISTANT CLERK<br>None       |  |
| 83. NAME OF CLERK<br>None                         |  | 84. NAME OF ASSISTANT CLERK<br>None       |  |
| 85. NAME OF CLERK<br>None                         |  | 86. NAME OF ASSISTANT CLERK<br>None       |  |
| 87. NAME OF CLERK<br>None                         |  | 88. NAME OF ASSISTANT CLERK<br>None       |  |
| 89. NAME OF CLERK<br>None                         |  | 90. NAME OF ASSISTANT CLERK<br>None       |  |
| 91. NAME OF CLERK<br>None                         |  | 92. NAME OF ASSISTANT CLERK<br>None       |  |
| 93. NAME OF CLERK<br>None                         |  | 94. NAME OF ASSISTANT CLERK<br>None       |  |
| 95. NAME OF CLERK<br>None                         |  | 96. NAME OF ASSISTANT CLERK<br>None       |  |
| 97. NAME OF CLERK<br>None                         |  | 98. NAME OF ASSISTANT CLERK<br>None       |  |
| 99. NAME OF CLERK<br>None                         |  | 100. NAME OF ASSISTANT CLERK<br>None      |  |

TO BE FILLED IN BY THE REGISTRAR



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home for. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14348 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14333

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg Md.</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>14 Yrs.</u>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg Md.</u>   |                                  | d. STREET ADDRESS<br><u>Sharpsburg Md.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Antietam Creek at Burnside Bridge</u>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Daisy</u> Middle <u>Virginia</u> Last <u>Teays</u>  |                                  | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>19 58</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH<br><u>Dec. 17 1913</u> |
| 9. AGE (in years last birthday)<br><u>44</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <u>11</u> Days <u>21</u> Hours <u></u> Min. <u></u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Labor</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Nursing Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Cabletown W. Va.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>William Tomblin</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Nancy Thompson</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>215 17 1913</u>   |   |
| 17. INFORMANT<br><u>Mr. Robert E. Teays</u>   |                                  | Address<br><u>Sharpsburg Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Suffocation due to drowning</u><br><u>975x</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u></u><br>DUE TO<br>(c) <u></u>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u></u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |                                  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Drowned self in Antietam Creek</u>                                 |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>4:45</u> a.m. <u>Dec. 9 19 58</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Antietam Creek</u>   |                                  | 20f. (City or town) (County) (State)<br><u>Sharpsburg Wash Md</u>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |   |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>   |                                  | DATE SIGNED <u>12-12-58</u>   |   |
| EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Dec. 13-58</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Samples Manor Cemetery</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Samples Manor Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert L. Leaf Williamsport, Md</u>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 15 '58</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>  |                                  |   |   |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14316 CERTIFICATE OF DEATH

14334

Reg. Dist. No.

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Washington County Hospital</b>  |                                     | d. STREET ADDRESS<br><b>1756 Pennsylvania Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lessie</b> Middle <b>May</b> Last <b>Trenary</b>  |                                     | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>4,</b> Year <b>19 58</b>   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 18, 1890</b>                                 |
| 9. AGE (In years last birthday)<br><b>68 yrs.</b>   |                                     | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>house wife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Rowlesburg, W. Va.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Lemuel Carrico</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Sarah C. Casseday</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>213-10-6839</b>   |   |
| 17. INFORMANT<br><b>Gibson S. Trenary, Hagerstown, Md.</b>  |                                     | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>50 hrs.</b><br><b>5 yrs.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>11-2-55</b> , 19____, to <b>12-4-58</b> , 19____, that I last saw the deceased alive on <b>12-4-58</b> , 19____, and that death occurred at <b>5:30P</b> M, from the causes and on the date stated above.  |                                     |   |   |
| ACTUAL SIGNATURE<br><b>Charles F. Hess</b>  |                                     | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Smithsburg, Md. 12-5-58</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Charles F. Hess, M.D.</b>   |                                     | M.D.  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 22b. DATE THEREOF<br><b>12-6-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>  |                                     | 24a. REC'D BY REGISTRAR<br>Date <b>DEC 8 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |                                     |   |   |



1980



## CERTIFICATE OF DEATH

14335

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CLEAR SPRING</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CLEAR SPRING</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>S. MARTIN ST.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JACOB</b> Middle <b>RUSSELL</b> Last <b>TROUPE</b>  |   | 4. DATE OF DEATH<br>Month <b>DEC.</b> Day <b>20</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 8, 1893</b>   |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>FRANKLIN CO. PA.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>SAMUEL TROUPE JR.</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>FLORENCE BREWER</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>  |   | 16. SOCIAL SECURITY NO.<br><b>705-10-4620</b>   |   |
| 17. INFORMANT<br><b>MRS RUSSELL TROUPE</b>   |   | Address<br><b>CLEAR SPRING, MD.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>DUE TO <b>420.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION</b><br>DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>(c) <b>3 YEARS</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MINUTES</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Active tuberculosis</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>MAY 23, 1955</b> , to <b>DECEMBER 20, 1955</b> , that I last saw the deceased alive on <b>DECEMBER 20, 1955</b> , and that death occurred at <b>4-20 P.M.</b> from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><i>Archie Robert Cohen</i>   |   | ADDRESS (Street, city or town, state) DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type)<br><b>ARCHIE ROBERT COHEN</b>  |   | <b>M.D. CLEAR SPRING, MARYLAND 12-21-58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>DEC. 23, 1958</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PAULS CEM.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>CLEAR SPRING, MD.</b>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>John F. Clark</i>   |   | ADDRESS<br><b>CLEAR SPRING, MD.</b>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Frank</i>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

11-35

100-100

11-35

|                                   |  |                                   |  |                                   |  |                                   |  |
|-----------------------------------|--|-----------------------------------|--|-----------------------------------|--|-----------------------------------|--|
| <p>1. NAME OF DECEASED</p>        |  | <p>2. SEX</p>                     |  | <p>3. AGE</p>                     |  | <p>4. DATE OF BIRTH</p>           |  |
| <p>5. PLACE OF BIRTH</p>          |  | <p>6. OCCUPATION</p>              |  | <p>7. CAUSE OF DEATH</p>          |  | <p>8. MANNER OF DEATH</p>         |  |
| <p>9. SIGNATURE OF PHYSICIAN</p>  |  | <p>10. SIGNATURE OF REGISTRAR</p> |  | <p>11. SIGNATURE OF WITNESSES</p> |  | <p>12. SIGNATURE OF DECEASED</p>  |  |
| <p>13. DATE OF DEATH</p>          |  | <p>14. TIME OF DEATH</p>          |  | <p>15. PLACE OF DEATH</p>         |  | <p>16. SIGNATURE OF DECEASED</p>  |  |
| <p>17. SIGNATURE OF PHYSICIAN</p> |  | <p>18. SIGNATURE OF REGISTRAR</p> |  | <p>19. SIGNATURE OF WITNESSES</p> |  | <p>20. SIGNATURE OF DECEASED</p>  |  |
| <p>21. DATE OF DEATH</p>          |  | <p>22. TIME OF DEATH</p>          |  | <p>23. PLACE OF DEATH</p>         |  | <p>24. SIGNATURE OF DECEASED</p>  |  |
| <p>25. SIGNATURE OF PHYSICIAN</p> |  | <p>26. SIGNATURE OF REGISTRAR</p> |  | <p>27. SIGNATURE OF WITNESSES</p> |  | <p>28. SIGNATURE OF DECEASED</p>  |  |
| <p>29. DATE OF DEATH</p>          |  | <p>30. TIME OF DEATH</p>          |  | <p>31. PLACE OF DEATH</p>         |  | <p>32. SIGNATURE OF DECEASED</p>  |  |
| <p>33. SIGNATURE OF PHYSICIAN</p> |  | <p>34. SIGNATURE OF REGISTRAR</p> |  | <p>35. SIGNATURE OF WITNESSES</p> |  | <p>36. SIGNATURE OF DECEASED</p>  |  |
| <p>37. DATE OF DEATH</p>          |  | <p>38. TIME OF DEATH</p>          |  | <p>39. PLACE OF DEATH</p>         |  | <p>40. SIGNATURE OF DECEASED</p>  |  |
| <p>41. SIGNATURE OF PHYSICIAN</p> |  | <p>42. SIGNATURE OF REGISTRAR</p> |  | <p>43. SIGNATURE OF WITNESSES</p> |  | <p>44. SIGNATURE OF DECEASED</p>  |  |
| <p>45. DATE OF DEATH</p>          |  | <p>46. TIME OF DEATH</p>          |  | <p>47. PLACE OF DEATH</p>         |  | <p>48. SIGNATURE OF DECEASED</p>  |  |
| <p>49. SIGNATURE OF PHYSICIAN</p> |  | <p>50. SIGNATURE OF REGISTRAR</p> |  | <p>51. SIGNATURE OF WITNESSES</p> |  | <p>52. SIGNATURE OF DECEASED</p>  |  |
| <p>53. DATE OF DEATH</p>          |  | <p>54. TIME OF DEATH</p>          |  | <p>55. PLACE OF DEATH</p>         |  | <p>56. SIGNATURE OF DECEASED</p>  |  |
| <p>57. SIGNATURE OF PHYSICIAN</p> |  | <p>58. SIGNATURE OF REGISTRAR</p> |  | <p>59. SIGNATURE OF WITNESSES</p> |  | <p>60. SIGNATURE OF DECEASED</p>  |  |
| <p>61. DATE OF DEATH</p>          |  | <p>62. TIME OF DEATH</p>          |  | <p>63. PLACE OF DEATH</p>         |  | <p>64. SIGNATURE OF DECEASED</p>  |  |
| <p>65. SIGNATURE OF PHYSICIAN</p> |  | <p>66. SIGNATURE OF REGISTRAR</p> |  | <p>67. SIGNATURE OF WITNESSES</p> |  | <p>68. SIGNATURE OF DECEASED</p>  |  |
| <p>69. DATE OF DEATH</p>          |  | <p>70. TIME OF DEATH</p>          |  | <p>71. PLACE OF DEATH</p>         |  | <p>72. SIGNATURE OF DECEASED</p>  |  |
| <p>73. SIGNATURE OF PHYSICIAN</p> |  | <p>74. SIGNATURE OF REGISTRAR</p> |  | <p>75. SIGNATURE OF WITNESSES</p> |  | <p>76. SIGNATURE OF DECEASED</p>  |  |
| <p>77. DATE OF DEATH</p>          |  | <p>78. TIME OF DEATH</p>          |  | <p>79. PLACE OF DEATH</p>         |  | <p>80. SIGNATURE OF DECEASED</p>  |  |
| <p>81. SIGNATURE OF PHYSICIAN</p> |  | <p>82. SIGNATURE OF REGISTRAR</p> |  | <p>83. SIGNATURE OF WITNESSES</p> |  | <p>84. SIGNATURE OF DECEASED</p>  |  |
| <p>85. DATE OF DEATH</p>          |  | <p>86. TIME OF DEATH</p>          |  | <p>87. PLACE OF DEATH</p>         |  | <p>88. SIGNATURE OF DECEASED</p>  |  |
| <p>89. SIGNATURE OF PHYSICIAN</p> |  | <p>90. SIGNATURE OF REGISTRAR</p> |  | <p>91. SIGNATURE OF WITNESSES</p> |  | <p>92. SIGNATURE OF DECEASED</p>  |  |
| <p>93. DATE OF DEATH</p>          |  | <p>94. TIME OF DEATH</p>          |  | <p>95. PLACE OF DEATH</p>         |  | <p>96. SIGNATURE OF DECEASED</p>  |  |
| <p>97. SIGNATURE OF PHYSICIAN</p> |  | <p>98. SIGNATURE OF REGISTRAR</p> |  | <p>99. SIGNATURE OF WITNESSES</p> |  | <p>100. SIGNATURE OF DECEASED</p> |  |



14317

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |   |   |   |                      |
|--|----------------------------------|---|--|---|---|---|----------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>20 Yrs</b>  |   |   |                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>145 East North Ave</b>  |                                  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>MARTIN</b> Last <b>WAGNER</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>19 58</b>   |   |   |                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 16 1883</b> | 9. AGE (In years last birthday)<br><b>75</b> yrs.   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |   | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stitcher</b>   |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pangborn Corp</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md</b>                          |                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |   |  |   |   |   |                      |
| 13. FATHER'S NAME<br><b>Hyatt Wagner</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Martih</b>  |   |   |                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  |   |  | 16. SOCIAL SECURITY NO.<br><b>312-14-7581</b>   |   | 17. INFORMANT<br><b>Mrs Esther A. Wagner</b> Address <b>145 E. North Ave</b>    |                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO <b>Hypertensive - arterio-sclerotic Cardio Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) <b>Diabetes Mellitus</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b> |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 yrs +</b>   |   |   |                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |                      |
| 20f. (City or town)<br><b>Hagerstown Md.</b>   |                                  |   |  | 20g. (County)<br><b>Hagerstown</b>  |   | 20h. (State)<br><b>Md.</b>  |                      |
| 21. I certify that I attended the deceased from <b>Oct 23, 1956</b> , to <b>Dec 23, 1958</b> , that I lost saw the deceased alive on <b>Dec 23, 1958</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.  |                                  |   |  |   |   |   |                      |
| ACTUAL SIGNATURE<br><b>F. F. Lusby</b>   |                                  |   |  | M.D. <b>230 N Potomac St</b>  |   | DATE SIGNED<br><b>24 Dec 58</b>   |                      |
| PHYSICIAN'S NAME (Type)<br><b>F. F. Lusby</b>  |                                  |   |  | <b>Hagerstown Md</b>  |   |   |                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12/26/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md.</b> |                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b> Address <b>Hagerstown Md.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hawks</b>                            |                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14318

## CERTIFICATE OF DEATH

14337

Reg. Dist. No.

|  |                                  |   |  |   |   |   |   |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>WASHINGTON</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>  |                                  |   |  | c. LENGTH OF STAY IN TB<br><b>20 YEARS</b>  |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>813 VIEW STREET</b>   |                                  |   |  | d. STREET ADDRESS<br><b>813 VIEW STREET</b>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MCPHERSON</b> Middle <b>SCOTT</b> Last <b>WEAVER</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>28</b> Year <b>1958</b>  |   |   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 18 1882</b> |   | 9. AGE (In years last birthday)<br><b>76</b> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                      |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer RETIRED</b>  |                                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>DANZER METAL WORKS BENEVOLA WASH.CO.MD.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 13. FATHER'S NAME<br><b>PETER JOHN WEAVER</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH TRONE</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  |   |  | 16. SOCIAL SECURITY NO.<br><b>220 10 3021</b>   |   | 17. INFORMANT<br><b>813 VIEW STREET MRS. MARY WEAVER HAGERSTOWN MD.</b>             |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO <b>Bilateral Nephroses</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Prostatic Hypertrophy</b><br>DUE TO <b>Prostatic Hypertrophy</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arterio-sclerosis generalized</b> |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Nov 9 - 1958</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |   |
|  |                                  |   |  | 20f. (City or town) (County) (State)  |   |   |   |
| 21. I certify that I attended the deceased from <b>Nov 9</b> , 19 <b>58</b> , to <b>Dec. 28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 22</b> , 19 <b>58</b> , and that death occurred at <b>12:30 P.</b> M, from the causes and on the date stated above.  |                                  |   |  |   |   |   |   |
| ACTUAL SIGNATURE <b>Sidney Hovenstein</b> M.D.   |                                  |   |  | ADDRESS (Street, city or town, state) <b>J. H. East Baltimore Md.</b> DATE SIGNED <b>12-30-58</b>   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>SIDNEY HOVENSTEIN</b>   |                                  |   |  |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>DEC. 31 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>FAHRNEYS CEMETERY</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>NEAR MAPLEVILLE WASH.CO.MD.</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. East</b>  |                                  |   |  | ADDRESS<br><b>Baltimore Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>Jan 2 '59</b>   |   |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. House</b>  |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







14350

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown Rural</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>3½ months</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Gateway Nursing Home</b>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>Theodore</b> Last <b>Weddles</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>22</b> Year <b>19 58</b>  |  |  |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 26, 1874</b>   |  |
| 9. AGE (In years last birthday) yrs. <b>84</b>  |  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>22</b> Hours <b>19</b> Min. <b>58</b> |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>contractor</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grading</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Adams County, Pa.</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>Jacob Weddles</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Souders</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>000</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs. George Weddles Hagerstown, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO <b>Arterial Sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>10 yrs.</b><br>(c) <b>10 yrs.</b> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sept 3, 1958</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Dec. 21, 1958</b> |  |
| 20f. (City or town)<br><b>Clearspring, Maryland</b>   |  |  |  | 20g. (County)<br><b>nr. Waynesboro Pa.</b>   |  |  |  |
| 21. I certify that I attended the deceased from <b>Sept. 3, 1958</b> to <b>Dec. 22, 1958</b> , that I last saw the deceased alive on <b>Dec. 21, 1958</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>David R. Brewer</b>  |  |  |  | ADDRESS (Street, city or town, state)<br><b>Clearspring, Maryland</b>  |  |  |  |
| DATE SIGNED<br><b>12/23/58</b>  |  |  |  | PHYSICIAN'S NAME (Type)<br><b>Dr. David R. Brewer</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 22b. DATE THEREOF<br><b>12-24-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Price Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>nr. Waynesboro Pa.</b>                     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kenna</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Washington

Baltimore

Maryland

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## CERTIFICATE OF DEATH

14319

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>                            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>47 years</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>947 Chestnut St.,</u>   |                                  | d. STREET ADDRESS<br><u>947 Chestnut St.,</u>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Abram</u> Middle <u>Weller</u> Last <u>Weller</u>  |                                  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>3</u> Year <u>19 58</u>   |  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>Sept. 20, 1879</u>  |
| 9. AGE (In years last birthday)<br><u>79</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>general laborer</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>self employed</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Big Spring, Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Adam Weller</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Martha Shank</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>214-16-1100</u>  |  |
| 17. INFORMANT<br><u>Mrs. Elvie Weller</u>  |                                  | Address<br><u>Hagerstown, Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Nephrosclerosis</u><br><u>446X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> |                                  | INTERVAL BETWEEN ONSET <u>5 years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostate hypertrophy; cerebral arteriosclerosis; cerebral thrombosis</u>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Jan. 16</u> , 19 <u>46</u> to <u>Dec. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>58</u> , and that death occurred at <u>2:40A</u> M, from the causes and on the date stated above                                       |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>148 West Washington St. 12/3/58</u>  |  |
| ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D.  |                                  | PHYSICIAN'S NAME (Type)<br><u>B. B. Kneisley, M.D.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   |                                  | 22b. DATE THEREOF<br><u>12-6-58</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Kraiss</u>  |                                  | ADDRESS<br><u>Hagerstown, Md.</u>  |  |
| 24a. REC'D BY REGISTRAR<br><u>DEC 8 '58</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Christ S. Kraiss</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



DEATH

CONFIDENTIAL

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 100

|                     |  |        |  |         |  |                  |  |                   |  |                    |  |                  |  |                   |  |                   |  |                     |  |                            |  |                            |  |
|---------------------|--|--------|--|---------|--|------------------|--|-------------------|--|--------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased |  | 2. Sex |  | 3. Race |  | 4. Date of birth |  | 5. Place of birth |  | 6. Usual residence |  | 7. Date of death |  | 8. Place of death |  | 9. Cause of death |  | 10. Manner of death |  | 11. Signature of physician |  | 12. Signature of registrar |  |
|                     |  |        |  |         |  |                  |  |                   |  |                    |  |                  |  |                   |  |                   |  |                     |  |                            |  |                            |  |
|                     |  |        |  |         |  |                  |  |                   |  |                    |  |                  |  |                   |  |                   |  |                     |  |                            |  |                            |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14340

14320

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Washington</u> <u>MARYLAND</u>  |                                  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Thurmont</u> <u>10x-2</u> ✓  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Washington County Hospital</u>  |                                  | d. STREET ADDRESS<br><u>Moser Road</u>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First <u>Richard</u> Middle <u>Olie</u> Last <u>Weller</u>   |                                  | <b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>3</u> Year <u>19 58</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 30, 1908</u> |
| 9. AGE (In years last birthday)<br><u>50</u> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Upholsterer</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Upholstering</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Frederick Co., Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13. FATHER'S NAME<br><u>Olie M. Weller</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Stull</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service)<br><u>Yes</u> <u>WW II</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>217-05-3981</u>   |  |
| 17. INFORMANT<br><u>Isabell L. Weller</u>  |                                  | Address<br><u>Thurmont, Maryland</u>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br><u>237X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema</u><br>DUE TO (c) <u>Brain tumor (operated)</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 minutes</u><br><u>3 days</u><br><u>3 months plus</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY: Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>58</u> , to <u>Dec. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>December 3</u> , 19 <u>58</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                        |                                  |   |  |
| ACTUAL SIGNATURE <u>A.F. Abdullah</u> M.D.   |                                  |   |  |
| PHYSICIAN'S NAME (Type) <u>A.F. Abdullah</u>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>12-6-58</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Blue Ridge Cemetery</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Thurmont, Maryland</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Raymond E. Creager</u>  |                                  | ADDRESS<br><u>Thurmont, Maryland</u>  |  |
| 24a. REC'D BY REGISTRAR<br><u>Dec 8 '58</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Hines</u>  |  |







## 14321 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>2 Hrs</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. county Hospital</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b><br>d. STREET ADDRESS <b>703 Maryland Ave</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANNA</b> Middle <b>MAY</b> Last <b>WENTLING</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>25</b> Year <b>58</b>   |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>Oct 22 1882</b>  |  |
| 9. AGE (In years last birthday) <b>76</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |  | 11. BIRTHPLACE (State or foreign country) <b>Middletown Fred Co. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |  |
| 13. FATHER'S NAME <b>George Ahalt</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Nancy Dusing</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>214-09-3152</b>  |  | 17. INFORMANT <b>Earl S. Wentling</b> Address <b>703 Maryland Ave</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>331X DUE TO <b>arterio-sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>athero-sclerosis</b><br>DUE TO (c) <b>arterio-sclerosis</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>mm</b><br><b>hrs.</b><br><b>mo</b>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>12/25/58</b> , 19 <b>58</b> , to <b>12/25/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12/25/58</b> , 19 <b>58</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <b>119 E. Chubbart Ave Hagerstown Md.</b> DATE SIGNED <b>12/26/58</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF M.D.</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>12/28/ 58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>DEC 29 '58</b> DATE   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1931

|                  |  |                |  |                 |  |               |  |                |  |               |  |                |  |           |  |
|------------------|--|----------------|--|-----------------|--|---------------|--|----------------|--|---------------|--|----------------|--|-----------|--|
| NAME OF DECEASED |  | SEX            |  | AGE             |  | DATE OF BIRTH |  | PLACE OF BIRTH |  | CITY          |  | COUNTY         |  | STATE     |  |
| JAMES H. HARRIS  |  | Male           |  | 45              |  | 1886          |  | Maryland       |  | Baltimore     |  | Baltimore      |  | Maryland  |  |
| OCCUPATION       |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | DATE OF DEATH |  | PLACE OF DEATH |  | CITY          |  | COUNTY         |  | STATE     |  |
| Carpenter        |  | Heart Disease  |  | Natural         |  | 1931          |  | Baltimore      |  | Baltimore     |  | Baltimore      |  | Maryland  |  |
| DATE OF DEATH    |  | PLACE OF DEATH |  | CITY            |  | COUNTY        |  | STATE          |  | DATE OF DEATH |  | PLACE OF DEATH |  | CITY      |  |
| 1931             |  | Baltimore      |  | Baltimore       |  | Baltimore     |  | Maryland       |  | 1931          |  | Baltimore      |  | Baltimore |  |
| DATE OF DEATH    |  | PLACE OF DEATH |  | CITY            |  | COUNTY        |  | STATE          |  | DATE OF DEATH |  | PLACE OF DEATH |  | CITY      |  |
| 1931             |  | Baltimore      |  | Baltimore       |  | Baltimore     |  | Maryland       |  | 1931          |  | Baltimore      |  | Baltimore |  |

THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, HAS RECEIVED THE ABOVE CERTIFICATE OF DEATH, AND THE DEATH OF THE DECEASED IS HEREBY CERTIFIED.

TO BE FILLED BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO BE FILLED BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO BE FILLED BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14351

## CERTIFICATE OF DEATH

Reg. Dist. No.

14342

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u><br>b. COUNTY <u>Washington</u>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>25 yrs.</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>132 Main Street</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Sidney</u> Middle <u>Eugene</u> Last <u>Whisner</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>11</u> Year <u>19 58</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 9 1875</u>                                |
| 9. AGE (In years last birthday) yrs. <u>83</u>  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>9</u> Dpys <u>1</u> Hours <u></u> Min. <u></u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret'd Foreman</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Steel Mill</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>WEST VIRGINIA</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A</u>   |  |
| 13. FATHER'S NAME<br><u>Issac Whisner</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Julia Stotler</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><u>214 05 9038</u>  |  |
| 17. INFORMANT<br><u>Mr. Eugene Whisner</u>  |                                  | Address<br><u>132 Main St. Sharpsburg Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>334x Central Arteriosclerosis</u><br>DUE TO (b) <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u><br>DUE TO (c) <u></u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><u>5 mths +</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>19</u> p. m. <u></u>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Aug 1, 1958</u> , to <u>Dec 8, 1958</u> , that I last saw the deceased alive on <u>12-8-58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>John D Turco</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>302 W. Potomac St. Washington, Md</u>   |  |
| PHYSICIAN'S NAME (Type) <u>JOHN D TURCO MD</u>  |                                  | DATE SIGNED <u>12-8-58</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Dec. 14-58</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Nt. View Cemetery</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Sharpsburg Maryland</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Albert L. Williams</u>   |                                  | ADDRESS<br><u>2714</u>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 15 '58</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 14322 CERTIFICATE OF DEATH

14344

Reg. Dist. No.

|   |                                  |   |   |   |   |  |  |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1232 Ravenwood Heights</b>   |                                  |   |   | e. STREET ADDRESS<br><b>1232 Ravenwood Heights</b>  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ERNEST</b> Middle <b>PAUL</b> Last <b>WOLFE SR.</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>11</b> Year <b>1958</b>  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 8, 1904</b> |   | 9. AGE (In years last birthday)<br><b>54</b> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Inspector</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fairchild Aircraft</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington County, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |
| 13. FATHER'S NAME<br><b>William D. Wolfe</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sadie B. Davis</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Mrs. E. P. Wolfe Sr. 1232 Ravenwood Hts.</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion (1<sup>st</sup> attack)</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Occlusion (2<sup>nd</sup> " )</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mos</b><br><b>2 1/2 wks</b> |                                  |   |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  |   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|   |                                  |   |   | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that I attended the deceased from <b>15 Sept</b> , 19 <b>58</b> , to <b>11 Dec</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11 Dec</b> , 19 <b>58</b> , and that death occurred at <b>1:15 A</b> M, from the causes and on the date stated above.  |                                  |   |   |   |   |  |  |
| ACTUAL SIGNATURE <b>F. F. Lusby</b>   |                                  |   |   | ADDRESS (Street, city or town, state) <b>230 N Potomac</b>  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>  |                                  |   |   | DATE SIGNED <b>12 Dec 58</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>12/14/58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. G. Horn</b>  |                                  |   |   | ADDRESS<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>Dec 15 '58</b>                      |  |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kears</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

|                  |                  |                  |                  |                  |                  |                  |                  |                  |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                   |                    |
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| 1. NAME OF PARTY | 2. NAME OF PARTY | 3. NAME OF PARTY | 4. NAME OF PARTY | 5. NAME OF PARTY | 6. NAME OF PARTY | 7. NAME OF PARTY | 8. NAME OF PARTY | 9. NAME OF PARTY | 10. NAME OF PARTY | 11. NAME OF PARTY | 12. NAME OF PARTY | 13. NAME OF PARTY | 14. NAME OF PARTY | 15. NAME OF PARTY | 16. NAME OF PARTY | 17. NAME OF PARTY | 18. NAME OF PARTY | 19. NAME OF PARTY | 20. NAME OF PARTY | 21. NAME OF PARTY | 22. NAME OF PARTY | 23. NAME OF PARTY | 24. NAME OF PARTY | 25. NAME OF PARTY | 26. NAME OF PARTY | 27. NAME OF PARTY | 28. NAME OF PARTY | 29. NAME OF PARTY | 30. NAME OF PARTY | 31. NAME OF PARTY | 32. NAME OF PARTY | 33. NAME OF PARTY | 34. NAME OF PARTY | 35. NAME OF PARTY | 36. NAME OF PARTY | 37. NAME OF PARTY | 38. NAME OF PARTY | 39. NAME OF PARTY | 40. NAME OF PARTY | 41. NAME OF PARTY | 42. NAME OF PARTY | 43. NAME OF PARTY | 44. NAME OF PARTY | 45. NAME OF PARTY | 46. NAME OF PARTY | 47. NAME OF PARTY | 48. NAME OF PARTY | 49. NAME OF PARTY | 50. NAME OF PARTY | 51. NAME OF PARTY | 52. NAME OF PARTY | 53. NAME OF PARTY | 54. NAME OF PARTY | 55. NAME OF PARTY | 56. NAME OF PARTY | 57. NAME OF PARTY | 58. NAME OF PARTY | 59. NAME OF PARTY | 60. NAME OF PARTY | 61. NAME OF PARTY | 62. NAME OF PARTY | 63. NAME OF PARTY | 64. NAME OF PARTY | 65. NAME OF PARTY | 66. NAME OF PARTY | 67. NAME OF PARTY | 68. NAME OF PARTY | 69. NAME OF PARTY | 70. NAME OF PARTY | 71. NAME OF PARTY | 72. NAME OF PARTY | 73. NAME OF PARTY | 74. NAME OF PARTY | 75. NAME OF PARTY | 76. NAME OF PARTY | 77. NAME OF PARTY | 78. NAME OF PARTY | 79. NAME OF PARTY | 80. NAME OF PARTY | 81. NAME OF PARTY | 82. NAME OF PARTY | 83. NAME OF PARTY | 84. NAME OF PARTY | 85. NAME OF PARTY | 86. NAME OF PARTY | 87. NAME OF PARTY | 88. NAME OF PARTY | 89. NAME OF PARTY | 90. NAME OF PARTY | 91. NAME OF PARTY | 92. NAME OF PARTY | 93. NAME OF PARTY | 94. NAME OF PARTY | 95. NAME OF PARTY | 96. NAME OF PARTY | 97. NAME OF PARTY | 98. NAME OF PARTY | 99. NAME OF PARTY | 100. NAME OF PARTY |
|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|--------------------|